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July 24, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Submitted via electronic submission

Re: CMS-2390-P, Medicaid and Children's Health Insurance Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; [42 CFR Parts 431, 423, 438, 440, 457 and 495]

Dear Administrator Slavitt:

On behalf of the American Dental Association (ADA) and its 158,000 members and the American Academy of Pediatric Dentistry (AAPD) and its 9,500 members, we are pleased to offer comment on the recent proposed rules 42 CFR Parts 431, 433, 438, et. all, *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability*, published on June 1 in the *Federal Register*. Medicaid and CHIP programs across the country provide dental services to both children and adults and our organizations appreciate the effort CMS has undertaken to better align Medicaid managed care with other sources of coverage.

Medical Loss Ratio as a Component of Actuarial Soundness: §438.4 and §438.5

We support the proposal to require Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) with Medicaid contracts beginning after January 1, 2017 to utilize a minimum medical loss

ratio (MLR) requirement in the development of actuarially sound rates. The ADA and AAPD agree with CMS that the MLR calculation and reporting are important tools to ensure that capitation rates set for Medicaid managed care programs are actuarially sound and based on reasonable expenditures on covered medical services for enrollees.

We support a minimum MLR of 85 percent and believe states should be cautious of setting higher MLR requirements to ensure that the threshold is adequate to accommodate administrative costs associated with delivering care and services. Monitoring how Medicaid managed care programs implement a minimum MLR is important given there may be differences between providing services to patients served in the Medicaid market as compared to providing services in the commercial market.

While we support the flexibility CMS proposes to grant to plans in developing activities related to service coordination, case management, and activities supporting community integration of individuals with complex needs while simultaneously adhering to a minimum MLR, we encourage strong oversight of the impact such activities have on the Medicaid population with respect to accessing and utilizing services, and the impact of such activities on managed care programs' abilities to coordinate care and ensure continuity of care. CMS should provide a clear definition for plans of what should be included or excluded as administrative costs, and develop standardized reporting requirements.

Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs: §438.2, §438.5, §438.6, §438.7

The proposed rule states that capitation rates should be "sufficient and appropriate for the anticipated service utilization of the populations and services covered under the contract and provide appropriate compensation to the health plans for reasonable non-benefit costs." We agree with the agency and support a more consistent and transparent documentation of the rate setting process. CMS proposes using rate cells to group people with more similar characteristics and expected health care costs together to set more accurate capitation rates. We request clarification on how dental risk for a population would be determined and used to create rate cells, if at all.

The ADA and AAPD believe that utilization targets are integral to the rate setting process to ensure services are accessed by all covered populations. We suggest State programs utilize existing data from commercial dental plans to create utilization benchmark targets for populations enrolled in Medicaid managed care plans. Including such a target will allow States to determine if rates have been appropriately set for a contracted MCO or PAHP or if further adjustments need to be made. Once a rate has been established using a specific utilization benchmark, the MCO or PAHP should be held accountable to achieve the utilization targets in the contract year. We urge strong

CMS oversight to ensure that both an actuarially sound rate is established and that the plan delivers the utilization benchmarks supported by those rates.

CMS states that "we request comment on methods, measures, and data sources that the states and their actuaries can use to assess whether capitation rates are adequate to support provider reimbursement levels that results in managed care plan provider networks that satisfy network adequacy and timely access standards." We encourage CMS and State programs to utilize existing research and seek expertise on dental payment rates and the relationship between access to and utilization of dental services in Medicaid. In addition to CMS published data, the ADA's Health Policy Institute (HPI) is a trusted source for policy knowledge on critical issues affecting the U.S. dental care system and has published research on Medicaid pediatric dental payment rates.[1] In its publication, CMS states that "providers in States where Medicaid does not reimburse at least at the break-even level have little financial incentive to participate." Actuarially sound capitation rates should demonstrate a balance that supports network adequacy.

Value-Based Payment

CMS proposes to allow States and managed care plans to establish methodologies or approaches affecting provider reimbursement that prioritize achieving health outcomes, not just delivering services. Additionally, CMS proposes building upon the Department of Health and Human Services (HHS) value-based purchasing targets for Medicare's fee-for-service program for years 2016-2018. The HHS framework imposes a tight timeframe to shift 30 percent of all Medicare payments to alternative payment models by the end of 2016 and 50 percent by the end of 2018.

We caution against moving too quickly into a value-based payment system for Medicaid dental providers. We urge CMS, States and managed care plans to utilize existing data and measures prior to shifting all Medicaid providers into a value-based payment system. Value-based payment would require the use of quality measures specified for providers. Currently there are not any performance measures that are valid and specified at the provider level. The use of measures that are unreliable or invalid undermines confidence in measures among providers and consumers of healthcare. It is also crucially important that patient health status and patient engagement (i.e. risk adjustment) be incorporated into any outcome measures used for the purpose of

[1] Nasseh K, Vujicic M. Are Medicaid and private dental insurance payment rates for pediatric dental services keeping up with inflation? Health Policy Institute Research Brief. American Dental Association. December 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1214_2.ashx.
Nasseh K, Vujicic M, Yarbrough C. A ten-year, state-by-state, analysis of Medicaid fee-for-service reimbursement rates for dental care services. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx
Centers for Medicare and Medicaid Services. Keep Kids Smiling: Promoting oral Health through the Medicaid Benefit for Children and Adolescents. September 2013. Available from: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf

determining value based payment. We urge CMS to work with professional societies and multi-stakeholder alliances like the Dental Quality Alliance (DQA)[2] before embarking on any effort to move payment for dental services into the value based model.

Minimum Payment

The proposed rule supports two practices to help ensure timely access to high-quality, integrated care including setting minimum reimbursement standards or fee schedules for providers that deliver a particular covered service and raising provider rates in an effort to enhance the accessibility or quality of covered services. The ADA and AAPD strongly support this provision. We urge States and managed care plans to reach out to dental stakeholders, utilize existing dental fee and claims data and analyze utilization patterns as part of any process to set minimum dental provider fees. As previously noted, CMS has identified a relationship between beneficiary access to dental services and payment rates. Determining an appropriate actuarial value, establishing an adequate dental provider network and setting a minimum payment level are all elements that ultimately translate into timely access for enrolled individuals. We commend CMS for noting that "The maintenance of an adequate network that provides timely access to services and ensures coordination and continuity of care is an obligation on the managed care plan for ensuring access to services under the contract. In the event concerns in these areas arise, the review of the rate certification would explore whether the provider rates are sufficient to support the MCOs PIHP, or PAHP obligations."

Program Integrity §438.600, §438.602, §438.64, §438.606, §438.608, and §438.610

Our organizations support increased efforts by CMS and States to strengthen program integrity in Medicaid. We support the proposal to streamline the provider credentialing process for providers and eliminate duplicative efforts. However, we are concerned that the proposal to require providers to enroll with Medicaid to order and refer may be problematic for Medicaid beneficiaries. While we anticipate such situations may be limited we believe this is an unnecessary requirement. The ADA and AAPD believe that a dentist's National Provider Identification (NPI) number along with a valid and active license from a State dental board should provide sufficient information for ordering and referring purposes.

Network Adequacy Standards: §438.68

The ADA believes in allowing any willing licensed dentist to care for Medicaid beneficiaries and strongly urges CMS to consider this to alleviate administrative issues

[2] The Dental Quality Alliance, established by the ADA at the request of CMS, is a partnership of 30 entities interested in collaboratively advancing performance measures to improve oral health, patient care and safety.

associated with becoming a Medicaid provider. However, for a program structured around managed care and networks, the ADA and AAPD agree with the importance of ensuring that dental plans offered within Medicaid managed care plans provide an adequate provider network to meet beneficiary needs, and that this network include specialty dental providers and general dentists to provide covered services.

We agree with the proposal to limit State flexibility in the design of network adequacy standards rather than to prescribe specific standards. While the proposed rule requires that States establish time and distance standards for specific network provider types, including pediatric dental services, it provides States flexibility in determining those time and distance standards. The ADA and AAPD encourage the agency to define pediatric dental services as requiring a specific provider network composed of pediatric and general dentists and other dental specialists, with unique time and distance standards. Additionally, because most States provide dental benefits to Medicaid eligible adults, we recommend CMS work with State programs to create adequacy standards to serve this growing population. We also note the need for MCOs and PAHPs to clearly identify "active" providers when determining network size to ensure access to care for all beneficiaries. The ADA and AAPD are available to assist CMS to defining network adequacy standards for dental services.

We do not support provider to beneficiary ratios as the sole means of assessing network adequacy. However, the complex geography of States may require different standards within any given State to address issues such as known health professional shortage areas or low provider-to-population ratios in rural communities. We encourage CMS to require States to address geographic variations when setting adequacy standards. In addition to geographic variations, we urge CMS to consider other parameters when establishing network adequacy standards. For example, in relation to dental network adequacy standards, some states have found it helpful to have standards stipulate between dental non-emergency and emergency care, setting different time standards for when a beneficiary can receive an appointment.

The network for primary care dental services for children consists of pediatric, specialty and general dentists; hence, network adequacy criteria for such services should include a robust number of pediatric, specialty and general dentists. We encourage CMS to acknowledge that the measure utilized by States to assess the network adequacy of pediatric dental services not be limited to assessing the number of pediatric dentists alone; that should simply be the starting point for building an adequate network for children. For those States that have Medicaid dental coverage for qualified adult populations, in most cases a general dentist is providing care to adults and children within a family. States introducing an adult Medicaid benefit often require the services of oral surgeons to meet the needs of the newly enrolled populations. Monitoring

treatment needs and establishing standards for most needed specialty services in addition to general practitioners should be part of the adequacy considerations.

We understand that there may be a need for a State to grant an exception to a managed care plan from the established provider networks standards, due to geography or physical limitations of a beneficiary. However, we urge CMS to monitor beneficiary access to dental services in the event such an exception is granted and to utilize existing performance measures and claims data as part of the process.

Additionally, the rule addresses out-of-network care provided by PAHPs. The ADA and AAPD support the inclusion of language specific to out-of-network services to ensure both continuity of coverage and that special needs patients are able to receive medically necessary dental services. This would include patients who may be receiving treatment that requires close coordination between medical and dental providers.

Network adequacy standards (such as time and distance standards) by themselves are insufficient to establish a robust Medicaid program. As noted earlier, we urge CMS to closely monitor access to and utilization of services. We do not believe the Healthcare Effectiveness Data and Information Set (HEDIS) measure, Annual Dental Visit, is a sufficient measure to determine beneficiary access to dental services. Instead we recommend that programmatic access measures developed by the DQA be used to assess utilization and access. We encourage CMS to support the sharing of information on how State Medicaid managed care and Children's Health Insurance Programs (CHIP) have set dental plan standards and how such standards have improved beneficiary access to dental services.

It is also important for CMS to acknowledge that setting parameters for State dental network adequacy measurements, and forming and maintaining adequate dental provider networks, is associated with Medicaid dental reimbursement rates and other associated barriers. These challenges are addressed in the previously mentioned publication, "Keep Kids Smiling: Promoting Oral Health through the Medicaid Benefit for Children and Adolescents" (September 2013).

Provider Directories and Network Certification

We support the requirement for managed care plans to submit network certification documentation annually and with CMS's proposal to standardize provider directories by utilizing application programming interfaces (APIs). Standardizing Medicaid directories may help reduce enrollee and provider confusion along with supporting continuity of care in the event enrollees move across state lines and need to reestablish a dental home. We agree with CMS that if standardized APIs were in place, applications could be created that are more useful and consumer friendly. However, we strongly

encourage CMS to require MCOs and PAHPs to have mechanisms in place to support timely and accurate updating of provider directories.

Comprehensive Quality Strategy: §431.500, §431.502, §431.504, §431.506, and §438.340

The ADA and AAPD support the proposed requirement for States to annually publish identified quality metrics and performance standards on their websites. We also support the suggestion by CMS that States continue to work cooperatively with stakeholders and other interested parties as they develop a comprehensive quality strategy. We strongly urge CMS and States to seek input from the DQA as part of the development of any quality strategy that includes the delivery of dental services in Medicaid. The DQA, a multi-stakeholder organization, includes the AAPD and federal agencies such as the CMS, the Agency for Healthcare Research and Quality, the Health Resources Services Administration and the Centers for Disease Control and Prevention, as well as major dental professional societies, payers, educators, health professions organizations both inside and outside dentistry, and a member from the general public, and is well positioned to collaborate, coordinate, and lead efforts in performance measurement and help improve oral health through its members' experience, expertise, and support.

We urge CMS to adopt programmatic and plan level measures developed by the DQA. The measure set titled "Dental Caries in Children: Prevention and Disease Management" is specified at plan and program level and is the first set of pediatric dental performance measures already in use in the Children Health Insurance Program (CHIP) core set.[3] Measures within this set have been endorsed by the National Quality Forum (NQF). In fact, Covered California will require all qualified dental plan contracts in 2016 to include the DQA pediatric performance measures. California believes this requirement will help expand best practices and improve dental quality care overall in the dental system.

We also note that CMS has proposed to apply quality standards to PAHPs and publicly report their measure scores. We strongly encourage CMS to apply the same measures used to assess dental PAHPs to the MCOs that include dental services. MCOs responsible for medical and dental services should be held similarly accountable for the dental component. As noted above, the Covered California effort provides a model for establishing a dental quality dashboard for managed care plans. We note that the current Quality Reporting System (QRS) being developed for the federal marketplaces only includes the HEDIS Annual Dental Visit measure. A single measure of utilization cannot be used to assess and report quality of oral healthcare. The DQA is best

[3] http://www.ada.org/en/science-research/dental-quality-alliance/dqa-measure-activities/access-to-pediatric-starter-set

positioned to provide a validated comprehensive measure set for use by MCOs and PAHPs.

We support efforts to require plan accreditation. We urge CMS to pursue standards for readiness assessment of an MCO or PAHP prior to a contract award. A readiness assessment should examine elements such as a plan's ability to provide dental services to Medicaid enrollees; quality improvement and utilization management function capability; the ability to provide an adequate, accessible network; the technical capacity to process claims; the ability to process grievances and appeals; systems for enrollee support and outreach; and systems for provider network support.

Enrollee Encounter Data: §438.242

We support the requirement for States to report enrollee encounter data, including services sub-capitated by an MCO, PIHP or PAHP to a provider. We request that for all Medicaid entities submitting encounter data to CMS (including MCOs, PIHPs, PAHPs and Federally Qualified Health Centers), CMS require that all data elements including individual service codes be submitted into the Medicaid Management Information Systems.

We appreciate the opportunity to comment on the proposed rule and look forward to working with CMS further to improve Medicaid dental programs. Should there be additional questions please feel free to contact Ms. Janice E. Kupiec with the ADA at 202-789-5177/kupiecj@ada.org or Mr. C. Scott Litch with AAPD at 312-337-2169/slitch@aapd.org.

Sincerely,

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