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January 11, 2019

Seema Verma, M.P.H.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

Attention: CMS-2408-P; Medicaid Program; Medicaid and Children's Health Insurance Program Managed Care.

Dear Administrator Verma:

On behalf of the 163,000 members of the American Dental Association (ADA) and the 10,500 members of the American Academy of Pediatric Dentistry (AAPD), we are writing to you in regards to the proposed rule, CMS-2408-P, on Medicaid and Children's Health Insurance Program (CHIP) Managed Care.

As organizations dedicated to helping dentists advance the overall oral health of the public, we recognize that Medicaid and CHIP managed care plans play an important role in providing access to dental care. We appreciate the Centers for Medicare and Medicaid Services' (CMS) efforts to find balance between maintaining critical beneficiary protections and providing states with flexibility in overseeing their managed care programs, and offer the following comments on how this can best be achieved in dentistry.

Actuarial Soundness Standards: Option to Develop and Certify a Rate Range (§ 438.4(C))
The rule would allow states to develop and certify a rate range per rate cell and proposes specific parameters for those ranges. The ADA and AAPD agree with CMS that states using a rate range should submit a rate certification and document risk-sharing mechanisms, and an actuary should certify the upper and lower margins of the range. These measures will help enhance the integrity and transparency of the rate setting process. However, we request clarification on how dental risk for a population would be determined and used for the rate ranges. We believe that utilization targets are integral to the rate setting process and suggest that state programs use existing data from commercial dental plans when developing the rate range.

Delivery System and Provider Payment Initiatives Under Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) Contracts (§ 438.6(A) And (C))
There is a strong correlation 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 enrollees. The ADA and AAPD support states requiring managed care plans to adopt minimum rates to ensure adequate access to providers. States and managed care plans should reach out to dental stakeholders, utilize existing dental fee and claims data, and analyze utilization patterns when developing these rates. We thank CMS for adding these state plan approved rates to the proposed rule and defining them as amounts calculated as a per unit price of services under CMS approved rate methodologies in the state plan. However, while we understand that value-based payment arrangements are impacted by many local factors, we do not agree with CMS' proposal to permit states to direct the amount or frequency of expenditures made by managed care plans or have multi-year payment arrangements under these new payment models. CMS needs to be able to oversee these expenditures on a frequent basis and ensure that they provide access to care.

Medical Loss Ratio Standards: Technical Correction (§ 438.8)

The ADA and AAPD support requiring managed care plans to utilize a minimum medical loss ratio (MLR) in the development of actuarially sound rates. We believe that there are differences between providing services to patients in the Medicaid market and providing services in the commercial market. We do not think that the 2016 managed care final rule should have allowed MCO, PIHP, or PAHP expenditures on activities related to fraud prevention, as adopted for the private market, to be incorporated into Medicaid. Therefore, we do not support the technical change in the proposed rule that would revise § 438.8(k)(1)(iii) to be consistent with the 2016 final rule.

Information Requirements: Information for All Enrollees of MCOs, PAHPs, and Primary Care Case Management (PCCM) Entities: Provider Directories (§ 438.10(H))

The ADA and AAPD support the proposed requirement that provider directories include the provider's cultural and linguistic competencies, and think that this is critical in order for patients to feel comfortable in selecting a provider, ensuring they will be better able to understand the provider's recommendations and treatment plan. This is especially important in Medicaid where patients have low-incomes, English may not be their first language, and health literacy levels may be low. These problems are compounded in the field of dentistry where patients often have a fear of visiting the dentist and need to connect with a provider who can explain dental procedures to them in simple, meaningful terms.

The ADA and AAPD also strongly believe in the importance of timely and accurate updating of provider directories, as this reduces confusion for beneficiaries and helps ensure that they know where they can access care under their plan. We are concerned about the proposal to allow for quarterly, rather than monthly, updates to paper directories if the managed care plan offers a mobile-enabled, electronic directory. As the proposed rule states, "research has shown that 64 percent of U.S. adults living in households with incomes less than $30,000 a year owned smartphones in 2016." Consequently, many low-income Medicaid beneficiaries may not have access to a smartphone. Requiring them to call the plan's

customer service line or the state to confirm if a provider is still in-network adds another layer of complexity and burden for these already vulnerable beneficiaries.

Network Adequacy Standards (§ 438.68)
We believe in the importance of ensuring that dental plans offered within Medicaid managed care plans include an adequate provider network that meets beneficiary needs. This network must include pediatric dentists, other specialty dental providers, and general dentists. States should not be given the flexibility to create definitions for specialists, and instead should recognize providers certified by the appropriate dental specialty board.

The ADA and AAPD are concerned about the proposal to eliminate the time and distance standards and instead allow states to choose from a variety of quantitative standards. Rural areas of states can face dental provider shortages that are not found among medical providers. We ask CMS to require states to address geographic variations when establishing network adequacy standards. Additionally, states should be required to have quantitative and non-quantitative standards that are unique to each provider type and type of care to ensure access regardless of location or mode of delivery. These standards should include wait time, appointment availability, and the ratio of Medicaid patients to non-Medicaid patients. For example, some states have found it helpful to have standards that stipulate dental emergency versus non-emergency care, and set different standards for when a beneficiary should receive an appointment.

The network for primary care dental services for children consists of pediatric, other specialty, and general dentists. Network adequacy criteria for children enrolled in Medicaid managed care plans should include a robust number of all of these providers. The ADA and AAPD encourage CMS to define pediatric dental services as requiring a specific provider network composed of pediatric, other specialty, and general dentists with unique time and distance standards compared to medical providers. If CMS provides states flexibility to use other quantitative standards, then states should be prohibited from simply assessing the number of pediatric dentists and instead should look at access to other specialty and general dentists who see children. For states that have adult Medicaid benefits, a general dentist often provides care to the whole family. Additionally, states that introduce a Medicaid adult dental benefit or that previously had this benefit but recently expanded Medicaid will need to ensure that the network includes appropriate specialists who meet the needs of new enrollees. Monitoring treatment needs and establishing standards for the most needed specialty services in addition to general practitioners should be part of the network adequacy considerations. The ADA and AAPD would be happy to assist CMS and states in defining network adequacy standards for dental services. Ultimately the validity of any network adequacy requirement should be confirmed by determining if utilization goals for the program have been met. The ADA and AAPD encourage CMS to look at the work the Dental Quality Alliance (DQA) has done on developing service utilization measures.

Enrollee Encounter Data (§ 438.242(C))
We agree with CMS that encounter data is critical for the proper monitoring and administration of the Medicaid program. While we understand states' hesitancy about sharing financial data, the allowed and paid amounts of claims are already included in the explanation of benefits given to beneficiaries. The ADA and AAPD support CMS' proposal to include the allowed amount and paid amount in the data collected in the Transformed Medicaid Statistical Information System (T-MSIS).

Medicaid Managed Care Quality Rating System (§ 438.334)
The ADA and AAPD appreciate the 2016 final rule's provision requiring states to operate a Medicaid managed care quality rating system (QRS). We thank CMS for working with stakeholders to develop this framework, and ask that CMS and the states seek input from the DQA. The DQA was established at the request of CMS, and as a mutli-stakeholder coalition, is well positioned to collaborate, coordinate, and lead efforts on access to care measures. The DQA has developed a comprehensive set of measures and obtained their endorsement from the National Quality Forum (NQF). These measures have been tested for validity, reliability, feasibility, and usability for use in state Medicaid programs and rely on standard data elements in administrative claims data, including patient ID, patient birthdate, enrollment information, date of service, place of service codes, revenue codes, dental procedure codes, and provider types. These data are readily available and can be easily retrieved for billing and reporting purposes. Please visit **www.ada.org/dqa** for more information.

We also recognize the challenges in applying these quality ratings across different states, and support the proposed revisions that would balance the goal of facilitating these comparisons of plan performance with the need for state flexibility. However, given that many states provide the dental benefit through a PAHP, we encourage CMS to assure that states have dental-specific QRS systems that includes a comprehensive measure set to assess oral health rather than a single measure within a broader set.

CHIP Conforming Changes to Reflect Medicaid Managed Care Proposals
We agree with CMS' proposal to apply the Medicaid changes described above to CHIP. This program provides much needed oral health services to children. Good oral health is an essential part of children's overall health and dental disease is linked to other medical conditions. Untreated dental disease can also lead to problems in school and can persist into adulthood, resulting in higher treatment costs and making it harder to find employment. It can also impact military readiness and the deployment of troops. The protections offered to children enrolled in Medicaid managed care should also apply to children enrolled in CHIP.

Thank you for the opportunity to comment on the proposed rule. We look forward to continuing to work with CMS to ensure that Medicaid and CHIP beneficiaries in managed care plans have access to quality dental care. Should you have any questions, please

contact Ms. Roxanne Yaghoubi at the ADA at 202-789-5179 and yaghoubir@ada.org and Mr. C. Scott Litch at the AAPD at 312-337-2169 and slitch@aapd.org.

Sincerely,

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ADA President

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