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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4203-NC
P.O. Box 8013
Baltimore, MD 21244-8013

To Whom It May Concern:

On behalf of our 162,000 dentist members, the American Dental Association (ADA) is pleased to respond to the request for information from the Centers for Medicare and Medicaid Services (CMS) on Medicare Advantage (MA). The following comments mostly pertain to expanding access with coverage and care with brief comments on health equity data, medical loss ratio, and engaging partners.

A. Advance Health Equity

11. How are MA plans currently using MA rebate dollars to advance health equity and to address SDOH? What data may be helpful to CMS and MA plans to better understand those benefits?

The ADA believes CMS should collect and analyze data on supplemental benefits for lower income enrollees. While it is known that MA is covering more seniors every year, it is not known if supplemental benefits such as dental are maintained for seniors at all income levels. Nor is it known how often and where rebate dollars are most often used for dental benefits specifically. The ADA believes that it is critical that CMS analyze data on supplemental benefits in the MA program, including who is enrolled by ages and income, what is covered, and what benefits are being utilized. These are important data points for determining how to best advance oral health equity for MA beneficiaries.

B. Expand Access: Coverage and Care

3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

The ADA is aware that enrollment in MA plans is expanding and more specifically that a high percentage of Part C plan beneficiaries have access to some kind of dental benefit.[1] However the range of services covered with these plans appears to widely differ with some plans covering only a preventive benefit and others offering a more comprehensive benefit. The ADA does not have data to quantify how many enrollees are getting the different types of dental

[1] Medicare Advantage 2020 Spotlight: First Look (kff.org)

benefits, and requests that CMS collect that data. We believe that standardization in the benefits offered as part of a Part C plan would be beneficial for consumers.

Beneficiaries need and deserve more transparency regarding dental benefits and plan design for their MA plan, including services covered, frequency limitations, and more. A 2021 Kaiser Family Foundation brief noted,[2] "Plans do not use standard language when defining their benefits and include varying levels of detail, making it challenging for consumers or researchers to compare the scope of covered benefits across plans." Many MA plans currently have "value added" dental services which is appealing from a marketing perspective and may drive beneficiaries to select these plans, but typically the specifics of the dental plan offering is not provided. In many cases, the dental component of MA plans is vague and ill-defined. Sometimes the benefits are extremely limited (e.g. the plan might only offer cleanings and not comprehensive care) and/or difficult to use (e.g. requiring prior authorization for many services), thereby making the plan much less valuable and useful to beneficiaries. However, beneficiaries often are not able to find information on the limitations of the dental benefit when picking a MA plan.

Further, commercials that beneficiaries are exposed to over television and other forms of multimedia, in our opinion, appear to portray the supplemental benefit as "dental insurance". This is misleading to the public, as "insurance" implies that the insurer pays all or a decent share of the cost of needed care. This is not consistent with the experience of many beneficiaries of MA supplemental dental plans due to the limited benefits packages and/or cost sharing requirements of the beneficiary. Stipulations on how these benefits ought to be portrayed in communication materials would improve consumer understanding of what to expect regarding coverage & costs and would help them to pick the plan that best meets their needs.

The inclusion of dental plan specifications in MA plans' Actuarial Value (AV) calculations could accomplish these goals and add transparency for beneficiaries, providers, administrators, researchers, and CMS. Additionally, during the MA enrollment process, it's critical that enrollees have a summary of benefits in easily understood language that fully explains what services are covered and what is not covered as well as how much a MA plan will pay for such services.

Lastly, we would also recommend that Part C plans that offer dental as a supplemental benefit publicly report some standardized quality measures.

5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

Teledentistry has the capability of expanding the reach of a dental home to provide needed dental care to populations experiencing distance barriers. These encounters typically involve a dental hygienist who is on site with the patient, expanding the reach of dental professionals and increasing access to care. Having teledentistry-capable dental teams can reduce wait times for initial visits, expedite treatment planning and treatment delivery, and triage cases based on the needs of the population being served. The care provided is equivalent to in-person care, and as such, insurer reimbursement of services must be made at the same rate that it would be for the services when provided in-person. Federal and state policy will continue to shape the utility and feasibility of these technologies in dental care delivery.

[2] Medicare and Dental Coverage: A Closer Look | KFF

6. What factors do MA plans consider when determining whether to make changes to their networks? How could current network adequacy requirements be updated to further support enrollee access to primary care, behavioral health services, and a wide range of specialty services? Are there access requirements from other federal health insurance options, such as Medicaid or the Affordable Care Act Marketplaces, with which MA could better align?

As CMS has acknowledged in the past, the availability of a robust provider network is crucial to the success of any health plan. Plans must work not only for beneficiaries, but also for providers in order to build and sustain an adequate network. Building such a network includes establishing reasonable and appropriate fees for providers. This helps ensure beneficiaries have access to needed care. As such, we recommend that CMS require MA plans to report on the following metrics representing various aspects of dental providers' experiences with and participation in the plans:

- Provider Participation
    - Percent of all licensed, practicing dentists in the jurisdiction who are enrolled
    - Distribution of dentists by the number of unique beneficiaries treated in the year (such as: 0, 1-9, 10-99, 100+)
    - Distribution of dentists by the number of and/or dollar amount of claims
- Network Adequacy
    - Percent of network meeting time/distance standard, broken down by specialty type (e.g., general dentists, pediatric dentists, oral surgeons, etc.) (Example standards may be "15 minutes travel time to a general dentist.")
    - Percent of network accepting new patients
    - Average wait time for an appointment for new patients
    - Average wait time for routine appointments for patients of record (e.g. 10-14 days)
    - Average wait time for urgent appointments in relation to a state standard (e.g. 48 hours)
- Credentialing
    - Average number of days from application receipt to credentialing application approval
    - Total providers credentialed
    - Initial applications: Total number received, percent approved, percent denied
    - Re-credentials: Numbers approved, denied
    - Terminations: Numbers voluntary, involuntary
- Claims Administration
    - Number of claims received
    - Percent of claims: fully approved, partially approved, appealed, denied
    - Percent of claims processed within 30 days
    - Payment accuracy
- Provider Satisfaction: Semi-annual survey of network dentists.
    - Percent of network dentists satisfied/very satisfied with:
        - Billing inquiry assistance
        - Appeals/grievance system
        - Claims adjudication
        - Prompt payment (i.e., issuing/delivery within 30 days)
        - Dentist handbook and notification of changes
        - EOB communications

7. What factors do MA plans consider when determining which supplemental benefits to offer, including offering Special Supplemental Benefits for the Chronically Ill (SSBCIs) and benefits under CMS' MA Value-Based Insurance Design (VBID) Model? How are MA plans partnering with third parties to deliver supplemental benefits?

The ADA agrees with CMS that it would be helpful to understand what factors MA plans use when deciding whether to offer supplemental dental benefits, including which dental services are covered under the benefit.

In addition to a simple and straightforward metric on the share of MA plans with a dental benefit incorporated, it would be prudent to collect information on subcontracting arrangements.

8. How are enrollees made aware of supplemental benefits for which they qualify? How do enrollees access supplemental benefits, what barriers may exist for full use of those benefits, and how could access be improved?

We urge CMS to require MA plan administrators to notify beneficiaries in writing by U.S. mail – upon enrollment and annually thereafter if plan changes occur– of all service areas and specific services for which they are eligible, directions on how to get more specific information on the terms of their plan, and directions on finding and making appointments with health care providers in the network. These hard copy notifications should include specific information on changes to the dental benefits and dental provider network, rather than general information on changes to the plan overall.

9. How do MA plans evaluate if supplemental benefits positively impact health outcomes for MA enrollees? What standardized data elements could CMS collect to better understand enrollee utilization of supplemental benefits and their impacts on health outcomes, social determinants of health, health equity, and enrollee cost sharing (in the MA program generally and in the MA VBID Model)?

We urge CMS to work with the ADA Dental Quality Alliance in the identification and endorsement of standardized tools for measuring beneficiary experience, such as the CAHPS Dental Plan Survey[3] (measuring beneficiary satisfaction with service delivery among those who successfully access services) and the Oral Health Impact Profile[4] (OHIP-5, a validated instrument for assessing oral health-related quality of life). These tools could be incorporated into the Medicare Current Beneficiary Survey and/or required for MA plans to administer to their beneficiaries and report back to CMS.

Additional information is needed from CMS regarding the beneficiary populations enrolled in Traditional Medicare plans, MA plans, and supplemental plans. To assess differences between the beneficiaries served by these plan types and evaluate whether care is being offered and delivered equitably to these different beneficiary populations, sociodemographic data – such as income, race and ethnicity, education, and more – needs to be available to CMS, plan administrators, researchers, and the public.

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[3] Agency for Healthcare Research and Quality. CAHPS Dental Plan Survey. U.S. Department of Health and Human Services. Available from: https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html. Accessed March 31, 2022.

[4] Naik A, John MT, Kohli N, Self K, Flynn P. Validation of the English-language version of 5-item Oral Health Impact Profile. J Prosthodont Res. 2016;60(2):85-91.

The Medicare Current Beneficiary Survey (MCBS) has been an excellent source of data and incredibly enlightening as the health care and research communities try to better understand Medicare beneficiary populations and their experiences with the dental component of their plans,[5] including:

- dental benefits availability
- dental utilization
- premiums for dental plans
- coinsurance and copayments
- annual maximum and its application (i.e., whether it applies for preventive services in addition to other covered procedures)
- total annual out of pocket spending

However, as noted in the 2021 Kaiser Family Foundation brief and mentioned above, "Plans do not use standard language when defining their benefits and include varying levels of detail, making it challenging for consumers or researchers to compare the scope of covered benefits across plans." The scope of covered services, frequency limitations, and cost-sharing requirements must be transparent to beneficiaries, CMS, and the public.

In addition to collecting data from beneficiaries via the MCBS, we recommend CMS require MA plan administrators to report the following metrics pertaining to beneficiary enrollment and utilization of dental services (as a proxy measurement for dental access) and other aspects of quality of care supported by MA plans:

- total number of beneficiaries (age, race and ethnicity, income, education, …)
- number of beneficiaries with a dental claim in a plan year (age, race and ethnicity, income, education, …) as a measure of access
- cost sharing (average benefit paid per user [among enrollees who had a dental visit], average benefit paid per beneficiary [among all enrollees], coinsurance, annual maximums, total average out of pocket spending, …)
- applicable measures for the older adult population from the Dental Quality Alliance[6]

D. Support Affordability and Sustainability

6. Are there potential improvements CMS could consider to the Medical Loss Ratio (MLR) methodology to ensure Medicare dollars are going towards beneficiary care?

Among the many MA plans that include dental benefits, dental benefit administrators have not been subject to the same transparency requirements that medical plan administrators have been reporting with the Medical Loss Ratio. It is unknown to both CMS and the general public what share of beneficiaries' premiums and funding from the Supplemental Medical Insurance currently go directly to the provision of dental care especially when rebate dollars do not completely subsidize the benefit offered and beneficiaries are charged an additional premium for covered dental services. As such, we suggest that CMS institute a Dental Loss Ratio (DLR) reporting requirement for the dental component of any MA plan. All MA plans offering dental benefits should be subject to this requirement regardless of the contractual relationships they have in place to administer the benefit (i.e., MA plans have the obligation to report "on behalf of" their dental subcontractor(s) when applicable).

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[5] Medicare and Dental Coverage: A Closer Look | KFF
[6] ADA Dental Quality Alliance, Measuring Oral Healthcare Quality for Older Adults Final Report, Nov. 2021.

E. Engage Partners

2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?

The ADA, representing the dental provider community, is eager to collaborate with CMS and MA plan administrators to promote the oral health of the public. We again urge CMS to work with the ADA Dental Quality Alliance in the identification and endorsement of standardized tools for measuring beneficiary experience, such as the CAHPS Dental Plan Survey (measuring beneficiary satisfaction with service delivery among those who successfully access services), the Oral Health Impact Profile (OHIP-5, a validated instrument for assessing oral health-related quality of life) and other measures of quality of the benefit offered to plan beneficiaries. The ADA is also willing to support efforts to define a standardized form to display a summary of benefits during the enrollment process as well as collaborating with stakeholders in overall supporting general transparency in coverage requirements for enrollees.

Working together, we believe all MA stakeholders can provide value to MA enrollees by seeking appropriate data where necessary to ensure established and sustainable networks of providers that are able to provide supplemental benefits like dental care.

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Thank you again for the opportunity to offer input on the MA Program and for your many efforts on these issues.

Sincerely,

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President

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