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February 13, 2023

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

Re: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule (CMS-4201-P)

To Whom It May Concern:

On behalf of our 159,000 dentist members, the American Dental Association (ADA) is pleased to respond to the proposed rule from the Centers for Medicare and Medicaid Services (CMS) on Medicare Advantage (MA), which provides Medicare-covered benefits to members and sometimes offers extra benefits that original Medicare doesn't cover, such as dental services. We appreciate CMS taking our previous comments[1] into account by prioritizing MA dental benefits, including as Administrator Brooks-LaSure said, by requiring "detailed reporting on supplemental benefit expenditures by plans in the medical loss ratio report -- this expenditure information on dental and other supplemental benefits will help us to evaluate and begin to address disparities and access."[2]The following comments mostly pertain to data collection, transparency in marketing, and quality improvement.

Data Collection

Today, about half of Medicare beneficiaries are enrolled in MA and it continues to grow in the number of enrollees each year. This growth means that it is important that we know more about the supplemental benefits offered to these beneficiaries, especially the dental benefits.

Recently, the U.S. Government Accountability Office (GAO) issued a report on MA's supplemental benefits where they make two recommendations to CMS. The first was that CMS clarify guidance on the extent to which encounter data submissions must include data on the utilization of supplemental benefits, and the second recommendation was that CMS address circumstances where submitting encounter data for supplemental benefits is challenging for MA plans.[3] The ADA agrees with the GAO and believes that CMS should collect and analyze data on supplemental benefits for MA enrollees and we are pleased to see that CMS agreed with the recommendations the GAO provided as an initial step in this direction of more detailed data collection.

As CMS proposes a health equity index reward system to incentivize Part C plans to focus on improving care for enrollees with social risk factors, the ADA believes CMS should collect and analyze data on supplemental benefits for lower income enrollees to improve oral health equity. 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, race & ethnicity, education 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.

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[1] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/advocacy/220831_ma_rfi_nosigs.pdf
[2] https://insidehealthpolicy.com/daily-news/brooks-lasure-prioritizes-ma-dental-benefits-insulin-costs-2023
[3] GAO, Medicare Advantage Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization, January 2023.

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,[4] 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[5]

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.[6] 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 benefits, and requests that CMS collect that data.

MA Marketing

CMS proposes several changes to help consumers during the enrollment process by establishing more transparency standards in marketing MA plans. As noted in the proposed rule, advertisements can have misleading tactics that are designed to attract a beneficiary's attention. Additionally, beneficiaries can be subject to additional marketing while on the phone and may be switched to a plan that is not well suited to meet the beneficiary's health care needs. These misleading tactics are particularly harmful to low-income seniors who may have limited health literacy skills, as well as seniors who suffer from cognitive difficulties. The ADA supports CMS' proposed changes, such as:

- not allowing MA organizations to engage in marketing that advertises benefits that are not available to beneficiaries in the service area where the marketing appears unless unavoidable in a local market,
- prohibiting marketing unless the names of the MA organizations that offer the benefits being advertised are clearly identified,
- prohibiting MA organizations from marketing any products or plans, benefits, or costs, unless the MA organization or marketing names are identified in the marketing material,

[4] Medicare and Dental Coverage: A Closer Look | KFF
[5] Dental Quality Alliance, Measuring Oral Healthcare Quality for Older Adults Final Report, Nov. 2021.
[6] Medicare Advantage 2020 Spotlight: First Look (kff.org)

- prohibiting MA organizations from including information about savings available to potential enrollees that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of Medicare beneficiaries,
- requiring each MA organization to provide the opt-out information to all its enrollees, regardless of plan intention to contact, at least annually in writing, instead of just one time.

This misleading advertising by MA plans can be particularly confusing in regard to the supplemental dental benefits offered by the plans. As CMS notes in the proposed rule, the commercials can sometimes advertise up to $2,500 in dental benefits, when the plans available to the beneficiary only have a $500 dental benefit. Beneficiaries need and deserve transparency regarding dental benefits and plan design for their MA plan, including the total amount of the benefit per year, the services covered, frequency limitations, and more. 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 are not provided. In many cases, the dental component of MA plans is vague and ill-defined, while in truth, 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). These limitations make 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 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 and 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. 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.

Quality Improvement

We recommend that Part C plans offering dental as a supplemental benefit publicly report some standardized quality measures. We believe this aligns with CMS' proposals on quality improvement by requiring MA organizations to incorporate one or more activities into their overall quality improvement program that reduce disparities in health and health care among their enrollees.

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 Dental Quality Alliance in the identification and endorsement of standardized tools for measuring beneficiary experience and other measures of quality of the benefit offered to plan beneficiaries. 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.

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The ADA looks forward to continuing to work with CMS and we would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. Please contact Mr. David Linn at the ADA at (202) 789-5170 and linnd@ada.org to facilitate further discussion.

Sincerely,

George R. Shepley, D.D.S.
President

Raymond A. Cohlmia, D.D.S.
Executive Director

GRS:RAC:dl