March 13, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-0057-P, Proposed Rule, Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program.

Dear Administrator Brooks-LaSure:

On behalf of the 159,000 members of the American Dental Association (ADA) and the 10,800 members of the American Academy of Pediatric Dentistry (AAPD), we are pleased to provide comments on the Proposed Rule on Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program. The ADA and AAPD commend the Centers for Medicare and Medicaid Services (CMS) for seeking to streamline, clarify, and reduce the burdens of the prior authorization process for patients and providers. The ADA and AAPD also thank CMS for continuing to promote interoperability to facilitate the exchange of information between providers, patients, and payers.

However, to both improve the prior authorization process and promote interoperability, CMS must take the different needs of dental practices and medical practices into account. Further, this proposal will be much more effective for dental data exchange if CMS focuses on educating, engaging, and incentivizing business partners to facilitate the move toward adoption of the standards discussed in this rule. Administrative efficiency can only be achieved if we have robust standards which are inclusive of specialties and small practices, and if all business partners use these standards to communicate information.

Exclusion of Stand-Alone Dental Plans
CMS proposes to exclude stand-alone dental plans (SADPs) offered as qualified health plans (QHPs) on federally-facilitated exchanges (FFEs) from the provisions of this proposed rule. CMS argues that that because of "relatively lower enrollment premium intake compared to individual market QHPs," requiring SADPs to comply with the provisions of this proposed rule would lead SADPs to drop out of FFEs, thus reducing access to dental care.

While the ADA and AAPD acknowledge the importance of tailoring policy to avoid decreasing access to care, we believe it is a mistake to exclude SADPs from compliance with the proposed rule. It is important that patients who are enrolled in SADPs and providers working with SADPs

benefit from the improvements to prior authorization and increased interoperability offered by the proposed rule. Excluding SADPs would also decrease CMS's leverage over electronic dental records vendors – few of whom are certified by the Office of the National Coordinator (ONC) – on the adoption of standards.

Furthermore, it is our understanding that the SADPs who participate in the Medicaid Managed Care market will be required to implement the provisions of this rule. Many of the entities serving as insurers in the Medicaid Managed Care market also participate in the Affordable Care Act (ACA) marketplace, so if they can implement the provisions of this rule in Medicaid, they should also be able to do so for the ACA marketplace.

For these reasons, the ADA and AAPD urge CMS to not exclude SADPs from this proposed rule. We encourage the Secretary to provide technical assistance, financial incentives, and time-limited safe harbor periods to enable these plans to meet the requirements of the final rule in order to prevent SADP attrition.

Claims Data Related to Supplemental Benefits

CMS notes that "Medicare Advantage Prescription Drug (MA-PD) plans that cover Part A, Part B, and Part D benefits, as well as supplemental benefits, are required to provide access to information about all those covered benefits through the Patient Access API."

The ADA and AAPD interpret this to mean that information regarding supplemental benefits such as dental benefits covered by Medicare Advantage (MA) plans should be made available through the Patient Access API. CMS should be aware that there are different data elements involved in dental claims data and medical claims data. This is especially true in the MA supplemental and CHIP markets, where dental benefits are more complicated than simple eligibility. Dental benefits in MA supplemental plans are modified by annual limits, co-insurance, waiting periods, and frequency limits. The same is true in CHIP. These differences for dental benefits and claims data must be taken into account to improve the interoperability of dental data, and not just medical and pharmacy data. The ADA and AAPD are actively working to modernize the data elements exchanged for eligibility, benefits, and claims through our Standards Committee on Dental Informatics, an ANSI accredited standards development organization**. We ask CMS to recognize that the Patient Access API in its current version may not be able to represent all the essential benefit information for dental. Advancement of standards versions and the management of multiple versions is a critical issue and is not sufficiently addressed in the proposed rule.**

Patient Access API: USCDI Data

The Code on Dental Procedures and Nomenclature, also known as Current Dental Terminology (CDT), is the only code set used in dentistry to document and report dental procedures. The CDT is a HIPAA-named standard and is mandated for use by dental providers and payers for dental claims. CDT is also the only code set used to document dental procedures that have been performed on patients in a dental record.

As currently specified, the United States Core Data for Interoperability (USCDI) does not clearly require the use of CDT codes for dental procedure data. Under USCDI version 1, CDT is listed as an optional vocabulary standard. Use of USCDI version 1 leads to confusion between the use of the CDT codes that are appropriate for dental procedures and SNOMED codes which are inadequate for dental procedures. USCDI versions 2 and 3 identify CDT as an applicable vocabulary standard but are nevertheless often interpreted by certain software vendors to be "optional" as they are preceded by limiting language that reads: "optional for technology which

records dental procedures." **It is our assertation that CDT is the only appropriate vocabulary standard for dental procedures and should be present to accurately represent dental clinical procedures in all health information technology.**

While the ADA and AAPD support ONC certification for dental vendors, most dental practices use electronic dental records and practice management systems that are unlikely to be ONC certified. Thus, connecting changes in standards to the ONC Certification Program would not benefit dental providers, nor remove barriers to the exchange of dental clinical or administrative data. We recognize that all stakeholders need time to plan, prepare, and implement and there may be significant costs involved in the adoption of new data classes and elements. However, delayed implementation will continue to impede national interoperability, and the limitations of health information software to accurately represent dental procedures will continue to have a direct impact on patients, providers, and quality reporting. **We ask CMS to move to at least USCDI version 2 which would encourage the industry to ensure that the data elements and classes made available through the Patient Access API are the most appropriate for information exchange. We further ask CMS to ensure that users of USCDI version 2 understand that CDT is optional only for systems that do not handle any dental data.**

<u>ASC X12 Version 5010x217 278 (X12 278) for Dental, Professional, and Institutional Requests for Review and Response</u>
The ADA and AAPD applaud CMS's efforts to promote the adoption of FHIR-based APIs and has worked closely with Health Level 7 (HL7) to develop dual Clinical Document Architecture (CDA) and FHIR implementation guides. The ADA and AAPD are also working with several HL7 workgroups on developing the dental content in various FHIR standards. **The ADA and AAPD strongly support incentives and significant investment in dental-specific FHIR-based pilots and technology to move the dental industry towards FHIR-based APIs for real-time exchange.**

The ADA and AAPD also support requiring covered entities to implement HL7 FHIR APIs that complement the HIPAA adopted transactions. As stated above, dental benefits are unique from medical and pharmacy benefits and are more complicated than eligibility alone. We hope that the effort to improve and advance a HL7 FHIR API for prior authorization will include opportunities to promote interoperable solutions to a broader group of providers and healthcare specialties such as dental.

<u>"Gold Carding" Programs for Prior Authorization</u>
The ADA and AAPD support gold carding programs for prior authorization. CMS and third-party payers should recognize the efforts of dentists who have a track record of complying with prior authorization requirements. This will help ensure timely access to care for patients, and will reduce administrative burdens for dentists. Gold carding could help the patients who need care the most – including underserved patients with severe dental disease – to get that care. Many dentists are small business owners and only have a limited number of staff members, and gold carding could also help improve their efficiency. **The measure used in gold carding should match that used in the Medicare Fee-for-Service Review Choice Demonstration for Home Health Services: a review affirmation rate or claim approval rate of 90 percent or greater over 6 months.**

<u>Recommended Standards to Support APIs</u>
The ADA and AAPD have several concerns about the recommended implementation guides (IGs) for the Patient Access, Provider Access, Provider Directory, Payer-to-Payer, and Prior Authorization Requirements, Documentation, and Decision APIs. It is our general belief that

these IGs may be able to present some dental data but to our knowledge they have not yet undergone testing and review for suitability for dental needs. We have worked in collaboration with HL7 to develop dual CDA and FHIR IGs based on ANSI/ADA Standard No. 1084: Reference Core Data Set for Communication Among Dental and Other Health Information Systems. These IGs provide the foundation for the technical specifications to extract, format, transmit, and receive a patient's demographic data, dental or medical encounter data, and clinical data for exchange among information systems in order to achieve syntactic and semantic interoperability. The dental specific HL7 CDA R2 Implementation Guide: Dental Data Exchange, Release 1, STU 1 - US Realm and HL7 FHIR® R4 Implementation Guide: Dental Data Exchange have valuable information modeling and profiling that would likely improve how dental information is exchanged in the recommended IGs. Although we applaud the efforts of HL7 and its workgroups to address the critical needs for data exchange and interoperability, the named IGs have yet to be vetted by the dental community. While it is our understanding that these IGs may support dental terminology and oral body structures, the ADA and AAPD question the suitability of these guides in relation to the business needs of our industry. **We encourage CMS to provide technical support and incentives for the dental industry in piloting and validating the standards named in this rule. The ADA and AAPD are willing to lend its support towards facilitating such initiatives.**

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Thank you again for the opportunity to comment on the proposed rule. The ADA and AAPD look forward to continuing to work with CMS. Should you have any questions, please do not hesitate to contact Ms. Roxanne Yaghoubi at yaghoubir@ada.org.

Sincerely,

George R. Shepley, D.D.S.   Amr M. Moursi, D.D.S., PhD
ADA President   AAPD President

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