Dear Administrator Tavenner:

On behalf of the American Dental Association (ADA) and its 157,000 members we appreciate the opportunity to comment on the Quality Rating System Scoring Specifications proposed by the Centers for Medicare and Medicaid Services (CMS). We applaud the work CMS has done on this issue.

Dental benefits can be offered through stand-alone dental plans (SADPs) as well as offered as an embedded benefit within qualified health plans (QHPs) and we believe accountability must be in place for both types of plans. While we note that the previous rules1 have indicated that CMS will eventually establish a similar quality rating system for SADPs; we would like to reiterate the need to hold QHPs accountable to the same extent for dental benefits. Ensuring such parity in the quality of the dental benefit offered through QHPs and SADPs is essential to protecting a consumer that chooses the embedded benefit.

While we appreciate the inclusion of oral health, the ADA would like to see a greater emphasis on measurement of the quality of oral health care. Dental decay is the most prevalent chronic condition in children – five times more common than asthma. Dental decay is largely preventable and plans must take a more active role in ensuring better access and promoting the use of preventive services by all enrollees. The ADA’s evidence-based guidelines illustrate the existing science and support specific preventive services. The inclusion of the annual dental visit measure is a start but it merely indicates service utilization rates and does not address the quality of care as defined by the Institute of Medicine.

A recent policy brief from the ADA reports2 that QHPs with the embedded dental benefit sometimes require patients to meet the medical deductible before they can receive even basic preventive oral health services. The out-of-pocket costs can be quite high when the dental benefit remains embedded. While some QHPs specifically waive the need to meet the deductible for preventive dental services, we are concerned that consumers do not have all the necessary information when purchasing the plan and may not be sensitive to these nuances. These differences simply create an

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1 Patient Protection and Affordable Care Act: Exchanges and Qualified Health plans, Quality Rating Systems (QRS), Framework Measures and Methodology
2 http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0314_1.pdf
undue financial barrier that affects the oral health of our population. The ADA believes that implementing oral health quality measures for QHPs should mitigate some of these effects while requiring the plans to be accountable for oral health.

In 2008 the ADA, at the request of CMS, established the Dental Quality Alliance (DQA). The DQA is a partnership of 30 entities interested in collaboratively advancing performance measurement to improve oral health, patient care and safety. In 2013, the DQA officially endorsed a set of pediatric oral health measures that are applicable across public and private programs and align with your agency’s current oral health strategy. The measure set was tested for feasibility, validity, reliability and usability based on the measure criteria included in the Children’s Health Insurance Program Reauthorization Act and that of the National Quality Forum. The ADA is currently engaged in efforts to educate public and private payers on the pediatric oral health measures. We hope CMS will consider inclusion of some of these measures to more specifically measure quality of oral health care within the QHPs.

As stated above, we are pleased to note that as the health exchanges mature, quality reporting requirements will be extended to stand-alone dental plans. As CMS begins planning for these enhancements we hope you will consider the ADA as a key stakeholder for help in developing similar frameworks for stand-alone dental plans.

We appreciate the opportunity to provide comments on the proposed Quality Rating System. The ADA believes that consumers must continue to have the ability to choose appropriate, affordable dental benefits that meet their needs as well as the needs of their children. We trust that CMS will take this into consideration as it moves forward with the process. Should there be any questions please contact Dr. Krishna Aravamudhan in the ADA’s Chicago office at aravamudhank@ada.org or 312-440-2772.

Sincerely,

Charles H. Norman, D.D.S.  
President

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Executive Director and Chief Operating Officer

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