November 13, 2017

Ms. Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Sent via email to: networkadequacy.mia@maryland.gov

RE: Proposed Regulations COMAR 31.10.45 Dental Network Adequacy

Dear Ms. Larson:

The National Association of Dental Plans (NADP) and the Alliance of Maryland Dental Plans (Alliance) appreciate the opportunity to provide comments on the proposed regulations, COMAR 31.10.45 regarding Dental Network Adequacy. NADP is the national trade organization representing dental benefit companies operating in the U.S. and the Alliance is the state trade association of dental benefit companies operating in the State. NADP and the Alliance appreciate the work that the Maryland Insurance Administration (MIA) has done on this issue and the MIA's willingness to work collaboratively with stakeholders. NADP and the Alliance would like to thank the MIA for its consideration of the comments submitted in February regarding the draft proposed regulations. While the proposed regulations address some of the concerns raised in our February letter, NADP and the Alliance have concerns with the proposed regulations.

In general, we would like to note that the proposed regulations affect the broader commercial market beyond those of the Federally Facilitated Marketplace (FFM). In order to earn and retain business, dental plans continually work to develop the most robust networks and plan offerings possible. Should dental plans fail to maintain competitive networks, the market will determine a plan's success or failure. We do not believe that it is appropriate for the proposed regulations to affect markets beyond the ACA/Health Reform business.

Our specific concerns are as follows and NADP and the Alliance hope that the MIA will consider our recommendations.

1. 31.10.45.03 B. Travel Distance Standards with respect to Essential Community Providers.

This provision requires dental plans to meet the FFM standard for contracting with essential community providers (ECPs). The FFM is designed for the individual market and mainly serves an un/underinsured population, typically including Federally Qualified Health Centers (FQHC), only some of which have dentists. The proposed regulations impact dental plans filed for the commercial market, including employer plans, which are not sectors that have traditionally utilized FQHCs.

In addition, dental plans have found it very difficult each year to meet the FFM ECP dental ratio, as most ECP dentists have declined to contract with commercial dental plans. Additionally, the Centers for Medicare and Medicaid Services (CMS) lists identifying FQHCs that offer dental services are often in error or the locations only provide limited services (e.g. an examination by a dental hygienist or dentist services only available at certain limited times). Our plans have acknowledged including ECPs within their networks has been problematic, expensive and not beneficial to their enrollees as long as other providers are available in the same geographic region. If implemented at the state level, Maryland would need to continue providing an updated list of ECPs and address the data integrity issues in current listings as it is unclear how ECPs would be determined/identified by dental plans. Without a current list of available ECPs operating in the State, dental plans will have difficulty in meeting the requirement to include "at least 20 percent of the available essential community providers in each of the urban, rural, and suburban areas."

In reviewing the network adequacy regulations of other states, we found that, outside of the FFM, no other state has required the ECP standard as proposed. We appreciate that the proposed regulations include a process for seeking a waiver of the dental network adequacy requirement. However, if a dental plan fulfills all other network adequacy requirements, the inability to meet the standards with respect to ECPs should not result in a finding that a dental plan's overall network is not adequate.

Recommendation 1: NADP and the Alliance recommend that the travel distance standard with respect to ECPs be stricken from the proposed regulations.

2. 31.10.45.03 Travel Distance Standards

The proposed regulations include travel distance standards for a number of dental specialty types which are recognized as specialties by the Maryland State Board of Dental Examiners. Over 80% of dentists are general dentists, in contrast to approximately 12% of physicians who focus on family practice. As 85% of services are delivered by a general dentist in an office setting, immediate and local access to dental specialists is less critical than it is for medical specialists. The level of specificity with regard to specialists is not necessary given the practice of dentistry. While some states may maintain different travel distance standards for categories of "general dentists" and "specialists," no other state employs the specificity with respect to dental specialists in the same manner as that in these proposed regulations.

In addition, general dentistry services do not typically require enrollees to spend the entire day at a dental office. Many enrollees may work in a different area from where they live. Enrollees who work in a

different location from where they live often look for dental providers near their place of employment rather than their residence. The proposed regulations regarding travel distance standards only measure distance from the enrollee's place of residence, but should allow for the travel distance measurement from an enrollee's workplace.

Recommendation 2: NADP and the Alliance recommend that the travel distance standards for providers other than general dentists be stricken from the proposed regulations. The NADP and the Alliance further recommend that travel distance should be measured from an enrollee's residence ***or workplace***.

3. 31.10.45.04 Appointment Waiting Standards and 31.10.45.06 Dental Network Adequacy Executive Summary Form

The proposed regulations provide that each carrier's provider panel must meet specific appointment waiting time standards based on the type of services sought. The proposed regulations further require carriers to report the percentage of enrollees for which the carriers meet the appointment waiting time standards and to include the total percentage of telehealth appointments counted as part of the appointment waiting time standard results. California regulations include appointment waiting time standards applicable to HMO and PPO plans; however, the California standards are broader for non-urgent and preventive care at 36 and 40 business days, respectively, and California does not define a specific method of measurement except that it must be addressed through a Quality Assurance Plan. Moreover, Maryland's proposed standards reference non-urgent specialty care, which could be more difficult to comply with than simply "non-urgent appointments."

Appointment waiting time standards are an unreliable measure of network adequacy as there are many factors affecting the waiting time that are not under the control of a dental plan. An appointment with a sought-after dentist with good reviews from patients and who may be on the list of Top Dentists in the region may have an appointment waiting time of longer than 30 calendar days. But, there may be other dentists in the dental plan's network located in the same area in which the patient is seeking dental services with a waiting time of less than 30 days. Reporting on the percentage of enrollees for which the carrier meets the appointment waiting time standards would involve tracking when each enrollee sought an appointment, which type of care was sought, and when the dental services were delivered. While the latter date could be provided on a dental claim form, the other data would constitute a new and significant process for information collection between the provider, carrier, and patient. Further, Current Dental Terminology (CDT) codes for telehealth appointments are not effective until January 1, 2018, there is currently no information on their usage, and it may take some time for providers to begin using them. While dental plans may appreciate being able to demonstrate access via telehealth, any reporting related to the new codes would be unreliable.

Recommendation 3: NADP and the Alliance recommend that the MIA reconsider the inclusion of appointment waiting time standards as a measure of network adequacy. There is broad choice in dental plans, especially DPPOs, and appointment waiting times are not a fair measurement of network adequacy.

Please do not hesitate to contact Eme Augustini at (972) 458-6998 x111 or eaugustini@nadp.org or Tinna Quigley at 240-476-9308 or tquigley@fblaw.com should you have any questions or concerns. We greatly appreciate the MIA's consideration of our concerns.

Sincerely,

Eme Augustini
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National Association of Dental Plans

Tinna Quigley
Executive Director
Alliance of Maryland Dental Plans