HB 4 (Formerly HB 692) Working Group on the Plan Preparation of a Medicaid Adult Dental Benefit

January 16, 2020
Minutes

Working Group Members Present: Henry Lipman, Dr. Sarah Finne, Mike Auerbach, Lisa Beaudoin, Erica Bodwell, Gail Brown, Nick Carano, Colleen Dowling, Joan Fitzgerald, Shirley Iacopino, Dr. Daniel Kana, Courtney Morin, Stephanie Pagliuca, Dr. Kelly Perry, Sen. Cindy Rosenwald, Alexandra Sosnowski, and Nicole Tower

Working Group Members Attending by Phone: Rep. Jennifer Bernet, Laural Dillon, Matthew Doucet, Holly Eaton, Joanne Fontana, Chris Kennedy, Janet Laatsch, Lisa DiMartino, Ed Shanshala

After introductions, Dr. Sarah Finne (Medicaid Dental Director) opened the meeting to discuss new information about two items that kept coming up during discussions as being important to the process of developing an adult dental benefit in New Hampshire but are not necessarily specifically related to the benefit itself.Over the past several weeks some exciting possibilities have arisen regarding these issues.

New Information

- There is an opportunity to re-establish a dental residency program in New Hampshire. It has been approximately ten years since New Hampshire had a residency program. Dr. Finne was approached by Jane Barrow of the Harvard School of Dental Medicine, regarding the State's readiness for a General Practice Residency (GPR) program. There is a HRSA funding opportunity for dental residencies - either to improve an existing residency or to establish a new program. A GPR program would train dentists to work in public health and rural areas, and to learn about health centers and mobile services. The HRSA grant offers the opportunity to have a multidisciplinary course with components on mobile services, teledentistry, geriatrics, and special needs, to mention a few options.

  The State needs to develop a pipeline to recruit dentists who want to locate and live in New Hampshire. Dr. Finne reached out to Stephanie Pagliuca, Bi-State Primary Care Association for additional information. Bi-State has successfully brought student interns to NH from the University of New England College of Dental Medicine (UNE). Many UNE students rotate throughout NH at any given time. A residency program offers advanced postgraduate training to dentists who want more clinical and public health experience. The prior program in New Hampshire at the VA Medical Center in Manchester (closed due to administration changes) was very successful in bringing dentists to NH . There are many dentists currently practicing in the state because of that program. Practice sites have been invited to a conference call scheduled for January 23rd. Harvard can administer the residency program as they haveexperience in doing so.

  Mike Auerbach informed the group about remote residency models citing NYU Langone Hospital's residency program. He said Harvard and Tufts may be interested in running a remote residency program with the dentist in a New Hampshire practice and the preceptor/supervisor being remote.

Stephanie Pagliuca recalled that the NYU Langone Dental Residency accredits postdocs via "Advanced Education in General Dentistry" (AEGD). AEGD programs are offered internationally. Although the program takes the administrative burden off the sites, it has different requirements than a GPR Residency including more clinical time. Bi-State has explored AEGD in the past but found a lack of "critical mass" necessary to successfully implement a program. The State can implement a GPR residency program with Harvard at any time, but the HRSA funding program makes "now" an opportune time. She suggested that the grant announcement be posted on the website.

Dr. Finne added that HRSA funding for five years would allow the state time to develop a sustainability plan for a residency program. At that point, the state should look at either continuing GPR or consider AEGD.

- Student Loan Repayment: A recent statewide Summit was held to discuss what is being covered and offered in the current loan repayment program. It was an opportunity for stakeholders to voice their concerns and needs based on their discipline. We all ask whether oral health is important to the general population; and what is the public perception of the importance of oral health? At the Summit participants broke out into 6 or 7 small groups, some groups did not include an oral health participant, yet every single group mentioned dentistry and increasing loan repayment for dentists as well as the need for oral health services. Public attitude is starting to change. The meeting's outcome is a future work group to continue to look at loan repayment priorities. Several professions have difficulties with various members of the team. Dentists and hygienists are part of our current loan repayment program.

Outcome Measures

Providers have had questions about measures. What could an outcome/performance measure look like in a Value-based program? Northeast Delta Dental and DentaQuest provided Dr. Finne background information on what they are doing for measures in certain programs. Keep in mind, whatever is measured in a plan is determined by the contract associated with the plan. States with similar benefits may have varied outcome measures.

Dr. Finne provided a simple example where a state contracts with a benefit manager with a capitated rate; the benefits manager contracts with dentists on a fee-for-service basis but includes provider incentives for delivery of certain services (e.g. a certain percentage of patients completing all recall appointments based on their risk assessment). At the end of a time period, an incentive could be paid on that metric. In this example there is no risk to providers. As time goes on during the course of the contract, the risk may shift from contractor to providers.

Erica Bodwell commented that Northeast Delta Dental incentivizes with no provider risk - all risk is on the plan. An example is a percentage of services rendered; or using a risk assessment tool. The provider community would be involved in developing the metric.

Dr. Finne provided a second example using a value-based program scorecard. The scorecard would include a list of different items to be performed. The scorecard would be used for both children and adults to include items such as risk assessment, sealants placed, completion of recall appointments, tracking information such as when a patient is seen for a problem-focus appointment, was there a follow-up? Where does a provider score fall at the end of the time period? There would need to be a

baseline year in order to measure improvement. Performance improvement is not all on the provider, as care management is important. For example, no-show programs and contracts including transportation need to be examined. Dr. Finne will put links on the HB4 website to:

- Dental Quality Alliance formed by the ADA with CMS and dental specialty groups.
- The National Committee for Quality Assurance (NCQA) collects the "Healthcare Effectiveness Data and Information Set" (HEDIS measures), a widely used performance improvement tool used by health plans and other health care organizations. We should look at what quality measures are included in HEDIS. Although HEDIS does not include oral health measures, we can develop HEDIS-like dental measures.

Henry Lipman: How do we finance this? What would be the reasonable interaction of the dental aspect and medical aspect for Emergency Department (ED) use driven by dental need. We need to think about how to develop measures that might capture savings by reducing ED and pharmaceutical costs associated with access issues.

Dr. Finne noted the importance of dental care management to include follow-up after an ED visit. The dental provider would not know that a patient was in the ED, but the carrier would know and could divert the patient from a future ED visit.

Henry Lipman: How do we connect pools of money? For instance, by incentivizing plans to reduce ED usage for dental, the savings is realized in the "medical bucket," not the "dental bucket". How do we establish financial cross-benefit so that finances align with the incentives?

Gail Brown: We should not only focus on ED savings, but on savings in chronic care and inpatient hospitalizations. We should look to what the Integrated Delivery Networks (IDNs) are doing.

Erica Bodwell asked, since we have medical through the MCOs, dental, and the state; could there be a shared savings contract between all three? For instance, savings realized in the ED where the carrier could pass the savings back to providers in either medical or dental?

Henry Lipman responded that typically incentivized savings are distributed by the carrier within primary care, not in specialties. Insofar as dental cost savings, the carrier would have to know how dental care is affecting medical cost savings. There is no way of knowing this without care coordination and management. It is easy for a carrier to see a negative aspect when a patient is getting most of their care through the ED or a patient has multiple hospitalizations, and care coordination handles this patient differently so that hospital stays are reduced. Good value provided by coordinated care.

Dr. Finne stated that the Legislature is mainly concerned with the current biennial budget. Savings realized in future biennia may offer a compelling argument but not always effective.

Henry Lipman stated that we need to look at the actuarial information on ED spend based on experiences in other states in order to state a reasonable estimate of the potential savings and to set targets.

Erica Bodwell: We can cost it out for the biennium.

Rep. Jennifer Bernet added that if we limit our thinking to one or more biennia, we won't get anything accomplished. We need to plan this. It will take time to fully implement. It has been done by other states so New Hampshire can do it regardless of the configuration of the Legislature.

Joan Fitzgerald commented that for special needs populations, medical dental silos affect more than just finances; there is a division in clinical records and a challenge on how to integrate what is best dentally within the patient's medical care plan.

Laural Dillon commented on the importance of care coordination and partnerships such as the pilot project for emergency department diversion between Mascoma Community Health Center and Alice Peck Day Memorial Hospital. They will have data to document savings.

Lisa DiMartino agreed with Laural Dillon on the importance of collecting data to show the Legislature the savings and how the programs benefit consumers.

Benefit Plan Design Discussion (see handout, "On the Plan Preparation of a Medicaid Adult Dental Benefit")

Dr. Finne explained that the handout is an effort to compile all that the Working Group has done over the course of its meetings and to make sure that everything that has been discussed is included. And that there is a clear blueprint of what the most important factors of each of these elements are that are part of the legislation. There are some elements such as Grievance and Appeals and the Office of Ombudsman that are the responsibility of the Department and will be determined by whatever type of contract is awarded. Our goal is to make sure that no important facet is omitted .

Eligibility and Enrollment

- Phase in all adults
- Phased rollout by eligibility group – much like what was done for managed care.
- Still considering phasing in the children's benefit at the same time.

Laural Dillon asked if there is a benefit to a phase-in approach. Is the budget something to consider?

Henry Lipman responded that the goal is to in bring everyone in. The question is can we provide enough value? If we cannot provide value, then we might use a phase-in approach.

Gail Brown recalled that the legislative mandate is comprehensive.

Shirley Iacopino explained that this is a new program , and in order to not put too much strain on the system, to consider the opportunity to ramp-up over time and finesse and fine-tune the system through care coordination and provider network development.

Joan Fitzgerald suggested looking at a cost-effective way to see what is in the patient pool. That assessment is done by Certified Public Health Dental Hygienists (CPHDHs) with established markers for referral (an algorithm for referral) to a dentist would create a model that private dentists could utilize.

Dr. Perry suggested that this can be achieved by involving teledentistry having the dentist weigh in without using expensive dental chair time. The Dental Board spells out the scope of practice for dental providers. Having providers working at the top of the scope of their practices fits into the NH dental model. It would require establishing billing for CPHDHs. There is also a need to establish payment for assessment/evaluation.

Henry Lipman remarked there is a need to contemplate rate filing through the CMS actuarial process. CMS uses a recipe of what they look for.

Dr. Finne suggested that the last two items discussed belong under Network Adequacy.

Gail Brown ask for clarification of the term, "all Medicaid adults".

Henry Lipman clarified that "all Medicaid adults" are those on Medicaid age 65 and younger which does not include dual eligibles . The current primary Medicaid program covers approximately 180,000 including children. It may also cover some waiver services.

Dan Kana asked to clarify that Long Term Supports and Services (LTSS) patients over 65 are not covered.

Henry Lipman will check on the "long-term care waiver". People under 65 in LTSS are covered under Medicaid medical and would be eligible.

Lisa DiMartino asked Henry Lipman if the waiver services include the DD Waiver?

Henry Lipman needs clarity concerning waiver populations.

Mike Auerbach stated that an important element not on the list is patient and provider communications to help navigate the system.

Gail Brown distributed a list public health focused programs that provide dental services to adults.

Erica Bodwell suggested that the number of dental chairs be added to the form.

Dr. Perry suggested listing appointment wait times.

Dr. Perry asked how prior approval (PA) would be handled or what would be the PA requirements? For instance, if there is a cap, then dentures for someone young would save restorative costs in the long term and would increase the patient's employability.

Dr. Finne responded that it would be a code by code element. Dr. Finne does not want PAs to pop up for a high percentage of the codes.But there is a need for criteria on some codes. For instance, orthodontics and third-molar extractions demand parameters so that those with the greatest need qualify for the benefit.

Henry Lipman stated as the process is designed, we will do it by procedure code, projected volume and per cost.

Lisa DiMartino agreed with Dr. Perry. Some medications for mental illness are hard on the teeth; patients can lose their teeth young and dentures will change their life.

Covered Dental Benefits – Scope of Services

Dr. Finne explained this is going to be an actuarial discussion.

Cost Benefit Analysis: Projected Expenditures Anticipated Cost Savings

Dr. Finne explained there are a lot of moving parts to be considered in terms of cost that will guide the decision. An ED data analysis will be available soon. The Department is working with Medicaid, Medicare, and CHIP Services Dental Association (MSDA) on a Return on Investment (ROI) analysis of adding the adult benefit using current fees. The report should be available soon to give us a sense of potential savings. Joan Fontana and Dr. Finne are reviewing the codes captured in the current adult ED data to evaluate accuracy.

- Evaluate a few additional diagnosis codes along with the primary diagnosis code in the ED data set – Erica Bodwell.
- Add inpatient costs associated with sepsis and other diagnoses caused by oral infection – Gail Brown

Henry Lipman asked Joanne Fontana to investigate costs associated with appropriate inpatient codes.

Case Management:

Add to list:

- Integration with medical (care management) - Henry Lipman
- Case management support with specialized dental knowledge – Joan Fitzgerald
- Managing linkage, facilitation, and engagement – Gail Brown
- ED diversion and follow-up – Dr. Perry

Network Adequacy – Recruitment Strategies and Provider Retention

- Add hospital settings – Gail Brown.

Lisa Beaudoin asked if programs used to dealing with the disabled populations exist. She reminded the group that clinician training to deal with the disability population is needed.

Joan Fitzgerald stated that care plans for disabled patients are very detailed and include designing desensitization programs that require work with therapists (occupational, speech and behavior) in order to get patients ready for dental care.

Dr. Finne responded that in a value-based plan there could be a bundle of services to provide this with services not in the current fee schedule.

Quality Metrics – Outcome Measures

Dr. Finne will fill in the quality metrics and measures based on today's discussion (see above).

Finance

Dr. Finne commented that the message has been clear that reimbursement rates need to be reasonable, and the administrative burden reduced and that includes several different things. Audits need to be performed by specialists.

Credentialing in Training – no comments

Transportation

Dr. Finne noted that we should consider the need for a reliable transportation vendor within the bigger Medicaid picture.

Other Support Services

Dr. Finne noted the importance of advisory boards, particularly the Dental Medicaid Advisory Committee which is a joint effort of NH Medicaid and the NH Dental Society. It is an opportunity for parties to keep lines of communications open, which is critical when bringing on an entirely new program. There will be a lot of questions and discussions.

Gail Brown commented that the Pediatric Dental Society should be part of the advisory group and that CPHDHs should be well represented. She also mentioned network adequacy and noted that there is a severe shortage of dental assistants (DAs).As a system, we need to explore ways to recruit and train DAs. She mentioned that NHTI has a new program that includes a 3-credit high school course applicable to the DA program.

Dr. Finne informed the group that DHHS has a workforce group dealing with other areas of medical professional shortage. She plans to inform the group of the dental assistant shortage.

Next Steps and Wrap-up

Next meeting will be scheduled in 4 weeks due to the Yankee Dental Conference.