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

February 27, 2020
Minutes

Working Group Members Present: Henry Lipman, Dr. Sarah Finne, Mike Auerbach, Lisa Beaudoin, Dr. Kristine Blackwelder, Erica Bodwell, Colleen Dowling, Joan Fitzgerald, Amy Girouard, Wendy Hedrick, Shirley Iacopino, Dr. Daniel Kana, Chris Kennedy, Janet Laatsch, Dr. Salman Malik, Courtney Morin, Joann Muldoon, Rep. Mark Pearson, Dr. Kelly Perry, Suzanne Petersen, Laura Ringelberg, Nancy Rollins, Sen. Cindy Rosenwald, Dr. Earle Simpson, Ed Shanshala, Alexandra Sosnowski, Kristine Stoddard, Nicole ST Hilaire, Carolyn Virtue, and Scott Westover

Working Group Members Attending by Phone: (Call was recorded) Rep. Jennifer Bernet, Laural Dillon, Garth Corriveau, Matthew Doucet, Holly Eaton, Joanne Fontana

Materials distributed via email:

1. Benefit Cost Estimates

After introductions, Dr. Sarah Finne (Medicaid Dental Director) brought the meeting to order and started on the meeting agenda items.

SB 754 Discussion

Started with where we are with the Fiscal Note for SB754 based on what's in the legislation and the range of work defined by Milliman and the types of services on a continuum from low to medium to high (refer to the Benefit Cost Estimates handout). This is the best we can do until we have a higher level of specificity. We've included things that need to be in the final cost for the legislators to consider in addition to claims costs such as administration, tax, transportation, costs associated with the fee schedule being brought up to the national average, and first year use rate impact. We are assuming the legislators will follow the way that they fund the Granite Advantage component so that the premium tax on the policies could be used as part of the share. The population for adults consists of two groups: standard Medicaid (38,238) and Granite Advantage (47,470). We receive 90% funding on the Granite Advantage population and 50% on standard. There is a challenge in the way the legislature has funded the Trust; in the last session, they would allow for potentially tapping into liquor money; but this is something they probably won't want to do.

There were a few comments submitted that were not addressed in the legislation. First date in the bill is May 1st and there is no certainty that the bill will be passed by then. Also, the process is fine if it is through a carve-out but if it's a carve-in there is a need to align contracts because we can't have staggered contracts with medical. There will probably be some amendments.

Benefit Cost Estimates Review

Modeling on a $1,500 annual cap excluding preventive services.

Erica Bodwell suggested that It might be worth looking at a $1,000 cap.

Dr. Finne commented that the cost estimates are the starting point. The key different between the medium and high models is that the high includes removable and fixed prosthetics. We need to see the cost difference in programs that include prosthetics. We may take the medium and pull a couple of things down from high to be where we want to be and see the impact on cost. For example, medium includes endodontics on all teeth; there are many states that limit endo to anterior teeth. We could limit endo to specific teeth to see what happens to the rate or move removable prosthetics from high to medium. The benefit cost estimates are per year and state cost numbers represent millions.

Michael Auerbach remarked that this will be tinkered with in Finance.

Henry Lipman remarked that they want to define adequate services that we want. They may be told a number that they need to meet.

Dr. Finne's guiding principal with the medium plan was to address preventive, endodontics, periodontics, and restorative in order to get people back to a healthy state. Then work on the next phase for providing prosthodontics. If the cards fall in the right way, we can include prosthodontics right away. Getting people stable and healthy must be the guiding motivation.

Dr. Blackwelder wholehearted agreed that we need to stabilize and get people healthy, but we also need to consider employability so that people can get jobs. To work toward adding prosthodontics may take a lot of time and it's hard to get work without front teeth.

Michael Auerbach pointed out the value of educating legislators on committees like Commerce, Finance, Health and Human Services about elements of the plan, so they understand the costs as well as the upstream savings and benefits to health, and employability.

Dr. Finne: the key distinction between the two models is that with the medium benefit plan we are not making people completely whole. This is a point that we must make, our return on investment when someone gets prosthodontics then gets a job and finally transitions to commercial insurance. We are providing information for the fiscal note and as we go through the legislative process, we hope to acquire a better understanding of what legislators have in mind.

Joan Fitzgerald mentioned the need to increase provider fees to national averages.

Michael Auerbach stated that the national average Medicaid rate to dentists is 61.8% of private insurance rates for children and 46.1% for adults and that the private rate is around 80% of fees charged by dentists.

Dr. Finne stated that the Department would love to bring rates up to commercial insurer rates but that is not going to happen; so, a compromise is necessary and bringing rates up to the Medicaid national average is an improvement. Also, as part of the plan we have added funds for care coordination and for transportation which should affect no-show rates.

Dr. Blackwelder said that it is not just fees that are barriers to providers joining the network but also administrative burden, and care coordination with rates being third on the list according to the recent survey.

Lisa Beaudoin asked how do we address care coordination when currently, there are gaps in care coordination with the two veteran MCOs both medical and dental especially for those with special circumstances who are under 21? This is not going to be written into SB754 but would need to be addressed in contracts. Simply sending out a letter to families saying their children should get a cleaning does not get the children into the office.

Henry Lipman reminded the group that dental is not currently in managed care. In the cost estimate care coordination funding is listed under administrative cost allowance. From the standpoint of children, the Department is look at moving the children into managed care.

Dr. Finne replied that starting in January, the Department sent letters out to parents stating that their child hadn't had a dental cleaning in 9 months. The Department is sharing the information with the MCOs, so they include that information in care and case management. The need for a dental cleaning will show up along with vaccinations due. Starting January 1st, the Department is also reporting missed and cancelled appointments so that eventually this data can be analyzed to identify trends. This is something that was put into the current contract. We need to wait for the data.

Nicole St. Hilaire mentioned that AmeriHealth Caritas is new as an MCO and is collecting data on dental for adults. They still have the same challenges as the other MCOs in reaching people. AmeriHealth Caritas has folded dental care management into their care management process because it is part of what they are offering as part of their value-added benefit.

Lisa Beaudoin said she has heard good things about AmeriHealth Caritas's care delivery and services.

Laural Dillon had a question about care coordination. She doesn't know how much flexibility there is with care coordination but historically with public health trying to educate the public and to monitor healthy behaviors doesn't necessarily work. The only way to know if strategies are working is to implement measurements.

Dr. Finne stated that this is what value-based care is all about. We need to make sure we are measuring the things that we're doing in order to meet the goals that we want. We also need to have a baseline of what we are reporting to the MCOs as a place to start. For instance, we will measure if we are getting a reduction in missed appointments. This is something that would be built into any new contract.

Henry Lipman: This is like a triathlon; the 1st leg of the triathlon was to get it on the agenda; the 2nd leg of the triathlon is to get policy; and the 3rd leg is contracting. Not too early to think about these things but we can't tackle them until we get through the policy side.

Henry Lipman thinks the RFI process will help get some more detailed information on how carriers are able to capture this information.

Joan Fitzgerald depending on the type of provider small, medium or large, care coordination will be different; it may be easier or challenging for providers to meet outcomes.

Dr. Finne stated that care coordination will develop with providers and right now this is difficult to define. We have touched on things that are very important. We need to know if the things we are doing to increase access and utilization are actually working and a letter being sent out to parents isn't

enough. However, the Department got a lot of calls in response to the letter from parents stating they made an appointment or were trying to get an appointment.

Lisa Beaudoin felt that it will be difficult to get a lot of families in to testify at the hearing because of the short notice and the hearing being right after school vacation.

Dr. Finne reminded the group that there will be more than one hearing.

Henry Lipman informed the group that the hearing was moved up to 2:30 from 2:45 on March 3rd.

Laural Dillon was wondering if we are thinking about getting new providers to join the network. How long is it going to take to credential them?

Dr. Finne replied that is all contracted. That is why there is a certain number of weeks or months built into the process. That is why some people get frustrated by how long things take. We need to work aggressively to assure network adequacy.

Shirley Iacopino shared that in federal rules there is a 90-day mandated requirement. There is an also an allowance for providers to work out of network for a number of days.

Dr. Finne stated that although it's contracted, DHHS also has to credential providers. DHHS will need their own network because there will still be some Medicaid members that will be FFS. Providers need to login into the Department's system to start-up. And, despite grumbling they will need to change their password every 90 days; this is a security requirement.

Michael Auerbach commented that dentists are very used to re-upping; they are used to it.

Michael Auerbach recommended that those planning to testify not read from paper. If you need to do that sign-in in support of the bill and submit written testimony; do not repeat messaging.

Dr. Finne will send out an email to the whole group with details of the hearing. The group has done a huge amount of important work.

Michael Auerbach suggested Dr. Finne also provide some bullet points on things to focus on in testimony.

Henry Lipman commented that it is important to share information on the different levels of benefits and to elaborate on why too little will not produce results e.g. why is a $500 cap is insufficient.

Dr. Finne offered the example of an early benefit program in Iowa; the cap was too low to adquately address treatment plans so that patients still had active decay after maxing out their benefit. There was a huge outcry and Iowa revamped the program. We need to emphasize there is the ethical issue of examining and treatment planning to at least make sure that we can provide care for the member's immediate needs. The benefit has to be at a certain level in order to provide that. Both plans have preventive outside of the cap.

Joan Fitzgerald commented that if the problem is caries you can certainly arrest it using stabilization techniques which is a cost-effective way of meeting member needs and then refer them on for higher-level care.

Dr. Finne mentioned that it would be wonderful to have a dentist who currently sees adults testify.

Michael Auerbach suggested Dr. Perry and Dr. Simpson.

Henry Lipman asked if there was anyone who could testify about health-related savings. For example, inflammatory response is a health risk and tied to many disorders.

Dr. Finne will include information on health-related implications in the fiscal note mentioning for instance a Spanish report on the impact of the inflammatory response including periodontal inflammation. Although they can't come up with upstream medical cost savings figures, the evidence is compelling that they exist.

Erica Bodwell will also attach research to Northeast Delta Dental's testimony.

Michael Auerbach asked about a national trend in reduced ER rates for nontraumatic dental visits.

Dr. Finne believes the national reduction in ER vists and associated costs for nontraumatic dental visits is a result of more states adding an adult Medicaid dental benefit.

Henry Lipman said the picture of the emergency only benefit use was 1 million in ED costs and dental claims of 2 million.

Erica Bodwell stated that we need to be careful that someone will look at 11 million and just reject the proposal.

Michael Auerbach stated there may be a few more dentists who will be willing to see a few more Medicaid patients. This is a step in the right direction.

Dr. Finne reiterated that we need solo dentists to join the network to make this work. We need "all hands-on deck".

Next Steps and Wrap-Up

- Meeting ended at 5:10pm.
- Next meeting Thursday, March 12, 2020, 4:00 – 6:00 PM
  NH Department of Health and Human Services
  Brown Building, Room 460, 129 Pleasant Street, Concord, NH 03301