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

March 12, 2020
Minutes

Working Group Members Present: Dr. Sarah Finne, Henry Lipman, Dr. Kristine Blackwelder, Gail Brown, Shirley Iacopino, and Dr. Kelly Perry

Working Group Members Attending by Phone: (Call was recorded) Nick Carano, Colleen Dowling, Matthew Doucet, Holly Eaton, Joanne Fontana, Dr. Whitney Goode, Dr. Skip Homicz, Dr. Daniel Kana, Helen Taft, David Wagner, and Scott Westover

Materials distributed previously via email:

- Benefit Cost Estimates
- Compendium of Innovations in Oral Health Delivery Systems

UPDATES:

SB754

Senator Cindy Rosenthal introduced SB754 to the senate floor where it passed 24 to 0. It will move on to the House. The original bill was amended and contains two date changes. On the first page of the bill as introduced line 26-27 stated, "The request for information shall be released no later than May 1, 2020" and that date has been changed to August 1, 2020 because the bill may not be passed by May 1. On the second page of the bill as introduced, line 2-3 stated, "The state plan amendment shall be submitted to the Centers for Medicare and Medicaid Services (CMS) no later than September 1, 2020"; this date was changed to November 1, 2020. Similarly, on line 14 which stated, "All necessary state plan amendments and waivers shall be submitted by September 1, 2020" that date was also changed to November 1, 2020. The Department must do an RFI and RFP before the Department can send something to CMS. The date for implementation remains April 1, 2021.

SLRP Advisory Committee

The Student Loan Repayment Program Advisory Committee met for the first time since it's Summit. The Committee continued the discussion regarding making student loans available to private practice dentists. This could become a public/private partnership. The portion that comes from the state could include a requirement that the dentist see a percentage of Medicaid patients; the percentage has not been determined. Private monies would come from different sources requiring different rules. This is a work in progress and no final decision have been made.

Dr. Perry asked if this is going to create a situation where FQHCs will find it more difficult to hire dentists? Dr. Finne that the committee would consider this when making a recommendation for the requirements for loan repayment, we do not want negative consequences.

DISCUSSION:

Benefit Cost Estimates

Dr. Finne asked what are the most import elements of the benefits? Program models are presented as a range of costs, but we need to be realistic on funding. We need to be mindful of being cost effective.

Henry Littman voiced concern that pressures affecting the economy may require that we accept "good" just so that we have something to build on. The Trust must support a part of the program and the Trust may have trouble supporting the high-end range. We don't want health care with dental to go away. The liquor funds are lower this year than last year.

Dr. Finne informed the group that an email came out from the DentaQuest Partnership for Oral Health Advancement regarding a study, "Hospital Utilization for Non-Traumatic Dental Conditions in Oregon from 2013 to 2015."

The age group 24-34 represented the highest rate of visits and 65% of individuals that went to the ED. These individuals are 11% of the age group but they are having a big impact (85%) on ED costs. This could in part be because of issues with wisdom teeth. This issue doesn't qualify for coverage under the emergency benefit. This could be a result of the cliff effect. We need to keep this in mind for this age group. We need to approach this in a different manner.

Joanne Fontana: There is data on emergency room savings. Chronic care savings will take longer.

Gail Brown commented that we need to be sure that the benefit is high enough to create and document upstream medical savings. Where is it going to show impact on health outcomes and on employability?

Dr. Finne one of the things that I want to stress is that we need to do enough to make changes in health. When working with Joanne Fontana and Matthew Doucet trying to come up with an estimate and picking codes, it was important to keep the preventive outside of the cap. Prevention is a critical piece for everyone, and we need to provide this regardless. Leaving prevention outside of the cap frees up more funds to treat active decay, do extractions etc. Depending on where we wind up with the cap, we have to plan that we may not be able to get everything done in year one. We may need to create two to three-year care plans with routine preventive services, so they don't get worse.

One of the reasons that I wanted this discussion is to understand, based on your experience in treating this population, what is important. Is there anything that we have not discussed - that is not included in the medium-level benefit - that you feel is necessary? The medium-level benefit as defined includes preventive, restorative, endodontics, single crowns, and periodontics but does not include dentures.

Dr. Perry stated her support of including dentures in the benefit. We need to think about two populations of dental patients (1) those you can restore and maintain their dentition and (2) those for which it is too late, and you can't maintain their dentition with all the restorative and prevention services in the world. For the 2nd group, there won't be any continuing restorative or preventive costs; they would need to spend the entire capped amount on prosthodontic care. Patients are going down one path or the other. You are not going to have a case where they get a full mouth of restorative and full mouth dentures. Now partial dentures are a different story, but if you have a preauthorization process where you wouldn't authorize for a single missing tooth, but you might if they are missing all their anteriors or if they are missing all their posteriors and are not functional. Most dentists are going to do it only when necessary, but you can control this via the preauthorization process.

Dr. Blackwelder: The cost of dentures is more than the cap. Is there a way of creating a "denture fast path" so they can get all their teeth removed and get the dentures without having to wait a year going edentulous?

Helen Taft said that if you are looking at employability as one of the values of the dental benefit, at Families First, we found that providing dentures was key. Edentulism is a barrier for employment.

Joanne Fontana stated that including dentures will raise the cost of the medium-level benefit, but it is feasible; she can create a hybrid model. Cost estimates will depend on how stringent the preauthorization process is and exactly what the requirements are. It would be good, if a private funding source could be developed for those with an imminent need for dentures.

Dr. Homicz recalled that Families First did a tremendous number of dentures. These were people who had multiple abscesses who wound up in the Emergency Department repeatedly. The outcome was improved functionality and employability.

Henry Lipman asked Joanne Fontana if it was possible for the listed $1.88 cost for first year pent-up demand be used later when demand is mitigated for funding higher order benefits? Joanne thought it possible.

Gail Brown talked about the adequacy of the network affecting the ability to mitigate pent up demand in a single year making these decisions hard to predict.

Henry Lipman said that sometimes when things are like this, the Department can create a risk corridor which is a mechanism to minimize the year-end losses of those who covered a disproportionate share of sicker patients. Like when the expansion population came on board, no one knew what their costs were going to look like. Trust funding, since the actuary can only go by estimates needs to set the rate to be adequate, but it may be too high or too low, so you share the risk with the plan.

Scott Westover echoed the well-founded concern about network capacity. AmeriHealth Caritas has a value-added adult dental benefit utilizing FQHCs and if they have to expand services, they would need to access mainstream dentists.

AmeriHealth Caritas now has over 1500 dates of service and many codes within those dates. He would like to put together the information and show it to the group so they can see where utilization is within preventive, diagnostic, restorative and limited periodontal. This information will illustrate where AmeriHealth Caritas has had the largest uptake. He also mentioned that they are using a FFS schedule which would be inadequate to grow the network beyond FQHCs.

Dr. Finne thinks this would be very useful and she will work with Scott Westover over the next couple of weeks to pull something together.

Gail Brown asked if Scott Westover could also provide all assumptions and limiting factors affecting the data.

Helen Taft would also like to know the impact found for the need for transportation and care management.

Scott Westover can provide an overlay of members accessing the dental benefit who are the highest risk in our care management projections as well as their complementary needs for transportation and other services.

Shirley Iacopino mentioned to Scott Westover that she spoke to Catrina regarding the ED diversion project where they are looking at abscesses treated in the medical office rather than in the ED.

Scott Westover commented that they are still seeing ED usage so there is still opportunity for improvement.

Dr. Homicz commented that FQHCs are a wonderful model for this population particularly when you're talking about coordinated care. There is no way to get away from engaging the private sector. The network that is meeting the needs of the under 21 population is woefully insufficient. The reimbursement rate is too low.

Dr. Finne responded that part of the cost estimate has a line to bring the reimbursement rate up to the national average. She has been frustrated over the last five years with only about 60% of our kids being seen which ironically places us very high (#4) as compared to other parts of the country but we are achieving this with a low number of dentists. She would like to see growth. We could be doing better with our really young kids. That's a message that we must get out across the state, "don't wait until your child is 5."

Joan Fitzgerald stated that in long term care facilities about 75% of the services can be handled by the hygienist's scope of practice and if you add the CPHDH scope you can pretty much stabilize this population

to a significant degree. We should look at how we can use our dental hygienists in mainstream dental practices to meet the needs of the long-term care population.

Dr. Kana stated that they are fulfilling their patient's denture needs using the 295 back-door method. The denture component would not affect long term care as much as the private sector. There is a big difference in the denture needs of a 55-year-old going back to work and a 95-year-old patient looking at nutrition.

Dr. Perry asked if perio maintenance and fluoride were covered by both models and was told that perio maintenance was included, and fluoride treatments for adults would also be covered. Sealants for adults need further discussion but since there are many areas in New Hampshire with non-fluoridated water systems there is a good argument for covering it.

Commented [RB1]:

Joan Fitzgerald mentioned that fluoride application for adults is critical in geriatrics.

Dr. Finne commented that we need to keep in mind that we are talking about value-based products which put a heavy emphasis on prevention. When the Department puts out the RFI and RFP this will be addressed.

Joan Fitzgerald commented that when we talk about increasing capacity and providers working at the top of the scope of their practice; and with the need for private dentists to take on more Medicaid patients; can we look at a different way of triaging or assessing a patient's needs? Can we look at different ways in a value-based system to bring the new patient into treatment, for instance those with special needs, medical issues, and infection? Can we train our mainstream practices on how to do this and do it well? Is there anything in the plan to attract them to be a provider and offer them tools?

Dr. Finne commented that this was a great place to segue to the next agenda item.

Innovative Programs

Dr. Finne started this part of the meeting by asking if participants had time to take a look at the Compendium of Innovations in Oral Health Delivery Systems document available on the link that she provided by email.

One of the things that is supposed to be included in our discussion is "innovation" and what innovation can do for us. What she took from the paper was the need to utilize our expanded workforce in terms of the CPHDH who can take X-rays; make a preliminary diagnosis; and send that information back using teledentistry. This is a useful way of triaging patients whether in an FQHC or private practice. This can change the perception of the private dental practice. You could have a CPHDH one day a week practice in an adult daycare providing prevention on the spot and developing a treatment plan. If the patient doesn't need to see a dentist, then prevention has been provided and for those who need to see a dentist the referral is made, and the dentist knows what to expect. We need to make sure that whatever benefit we go with and what vendor or vendors that we choose that they recognize that we need all the people in the field doing the treatment. CPDHD are licensed in the state and we need to make sure that this provider type is included. This is another way of our being able to provide something like an adequate network. We need everyone out there seeing patients.

There are a lot of good examples in the paper; things that are already being done. We don't have to reinvent the wheel. We can take a little bit from A and from B and come up with something that will work for New Hampshire.

Helen Taft was interested in the paper. Two of the programs discussed in the paper were from New Hampshire. I have some experience in an outreach-type program using mobile vans and school programs. There are a lot of different ways of reaching the people in those programs which makes a lot of sense in utilization of staff. Using all types of staff that are available and using the office as the place for additional

treatment. There is a way of designing the system to engage patients in different environments using a "field approach." The idea of integration with health and behavioral services is key to treat the whole person. There needs to be a systematic approach to the referral process so you're sending the person to the right setting. SeaCare Dental Service Network was a group of dentists who agreed to take Medicaid patients. The coordinator was a hygienist who could triage so that dentists knew something about the patient that they were receiving.

Dr. Blackwelder the care coordination piece comes under the domain of the MCOs, how does this come about when choosing a vendor or vendors? Who designs this?

Dr. Finne and Henry Lipman responded that the process is a combination and that's why the Department will do an RFI in order to get an idea of what is available from vendors and who is ready to provide what we need. The working group is very important in letting the Department know what is important to include in a benefit and this informs the questions asked in the RFI. The Department makes decisions on program design and posts an RFP.

Dr. Perry would the MCOs reimburse CPHDH? We are relatively well-poised to deploy a teledentistry model using CPHDHs. Some are already imbedded in programs and others can be added. There are between 40 to 60 licensed CPHDHs. We have good capacity for teledentistry with CPHDHs who are ready to go. The only thing missing is the ability for CPHDHs to be reimbursed. This will help save chair-time for the dentist. You can do the exams at a remote location like nursing homes, senior centers or schools. Many FQHCs have multiple locations but a single dental clinic; we can deploy CPHDHs to these other locations to do things there and leave the higher-level stuff to the dental center.

Dr. Finne this is where we need the link with the Dental Society; Mike Auerbach was not able to make this meeting. If one of the FQHCs and two private offices in an area hire CPHDHs who can go out and start screening, we have capacity in that area. We need to be working together. We need to have coordination in communities.

Dr. Perry asked can we expect this the type of coordination from MCOs?

Dr. Finne: This is a little outside of what a dental administrator would do. This is the responsibility of the stakeholders to design an adequate network. I was with a school program and we had to do a lot of outreach to make sure we had an adequate provider network to meet program needs; and that providers understood what we were doing and that we were not going to send 55 students to one provider.

Dr. Perry asked if there was already some entity that could assist in coordinating CPHDHs?

Dr. Finne responded that although some of us have talked about this, none exist.

Gail Brown brought up the IDNs (Integrated Delivery Networks) which are part of the Medicaid delivery system. They are funded to integrate behavioral health into primary care and IDN 6 (Exeter, Somersworth, Portsmouth, Rochester, Dover) also wants to integrate oral health. The Coalition is working with IDN6 on a Doc2Doc project to develop oral health linkages between primary care and dental; not just provider to provider but network development. Perhaps given this group's focus, we could design how to get some needed data out of the Doc2Doc project.

Helen Taft added that she is excited by the possibility of Doc2Doc to develop a model that could be replicated. She assumes that they will look at integration from a system point of view in making referrals to an adequate network that includes hygienists who can be deployed to different environments with private dentists as part of the network.

Dr. Blackwelder: There needs to be more training that goes along with this package. I would be perfectly willing to integrate a CPHDH into my practice, but I don't know how to do that. I don't know how that

would fit into my practice? What about liability? There is a coordination link that I don't know about. How do I go into a senior center?

Dr. Perry answered Dr. Blackwelder by saying that CPHDHs know how to do this and what equipment is needed but they need coordination with a dental practice for when they have identified need. The dentist provides the network to refer to. The dentist needs to know how to remotely do the exam but not necessarily how to deploy the service.

Joan Fitzgerald when speaking about innovations, I had to do a lot of the training myself and use other innovative ideas.

Gail Brown informed the group that Minnesota has used mid-levels in private offices. They might be a resource of information.

Dr. Finne: There are states that have had to deploy mid-levels or therapist so there are resources available. In communities, you must look around to see if there are pockets of individual need or congregating sites. But Dr. Blackwelder is right that this is new territory for private dentists.

Dr. Perry noted that there are organization dedicated to telehealth, so we just need to look at the resources.

Joan Fitzgerald noted that when cost effectiveness is a key element you need to look at practices differently.

Dr. Homicz stated this whole integration thing looks different in different settings. Even in a co-located FQHC, patients needed a warm handoff to complete the referral. Communication between the sectors is essential. He quoted from the Heath Partners of Western Ohio case study in "Compendium of Innovations in Oral Health Delivery Systems" which noted a barrier "Dental service integration requires a more concerted effort since dental care does not have the same visibility or urgency compared to other treatment needs."

Kelly Perry noted that we need to allow practices that want to be innovative to be innovative. You can manage your practice exactly as you do now, but some practices might be poised for change and use teledentistry, CPHDHs or EFDAs so we want to allow those things to grow capacity.

Dr. Blackwelder pointed out that we need care coordination because we still need the traditional mainstream dentist.

Dr. Finne there are going to be bumps in the road as the network grows; alternative models of practice will also proliferate with experience. The lightbulb will go on and a traditional practice will notice a population not being served and reach out to find out how to serve that population in an innovative way.

Next Steps and Wrap-Up

- Meeting ended at 5:45 pm.
- Next meeting Thursday, March 26, 2020, 4:00 – 6:00 PM
  NH Department of Health and Human Services
  Brown Building, Room 460, 129 Pleasant Street, Concord, NH 03301