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

December 5, 2019
Minutes

Working Group Members Present: Dr. Sarah Finne, Shirley Iacopino, Sen. Cindy Rosenwald, Ed Shanshala, Erica Bodwell, Dr. Kelly Perry, Dr. Kristine Blackwelder, Joan Fitzgerald, Nicole Tower, Laural Dillon, Gail Brown.
By phone: Stephanie Pagliuca and Holly Eaton

Dr. Sarah Finne (Medicaid Dental Director) opened the meeting noting that the Working Group will continue to meet in 2020; the schedule will be updated on the webpage as soon as possible; the next meeting will focus on the presentation by the Department's actuary; and work on an ROI for the adult benefit by Medicaid|Medicare|CHIP Services Dental Association (MSDA) is planned. Today's meeting is focused on the presentation of environmental scan information by the NH Dental Society and an organization providing mobile dental services in nursing facilities.

Dr. Kristine Blackwelder and Dr. Kelly Perry presented the following information, with conversation and questions (which follow this summary) interspersed.

1. Approximately 11% of member dentists participated in the survey(s). Of those, 85% are general dentists and 85% are in private practice. On average, there are 1.75 full-time (FT) dentists and 0.9 part-time (PT) dentists in each practice. These offices employ 2.5 FT hygienists and 1.5 PT hygienists, 3.3 FT assistants, and 0.9 PT assistants, in a setting with 6.3 operatories.

2. 72% said they would consider participating in an adult Medicaid benefit if reimbursement and administrative burden are addressed.

3. When asked how many hours a month would they be willing to see this population, they responded (average) 18 hours.

   Discussion: E Bodwell suggested taking the hours available to see patients per month and extrapolate to get an estimate of potential chair-time available to see members given x number of providers in a network and MCO support for providers to match available time with members through innovative scheduling.

4. Major barriers:
   a. Reimbursement: It is not possible to cover overhead at current rates.
   b. No-shows/lack of patient accountability: need for care coordination and a program that incentivizes patient accountability.
   c. Lack of specialists: need for a robust network for referrals, especially oral surgery.
   d. Administrative burden: simplify enrollment and re-credentialing, and ensure timely reimbursement and pre-authorizations.
   e. Audits: audits must be reasonable, fair, minimally invasive, and conducted by actual dentists.
   f. Lack of value: statewide program to elevate the value of oral health.

Discussion: Lisa Beaudoin stated that MCO support providers and members. G Brown mentioned people like Helen Taft who have experience working in patient management and accountability. E Shanshala discussed the importance of starting with emergency department doctors' education on appropriate and available alternatives to just prescribing meds, such as ED diversion programs to specific locations and then following up with providers to support reduction of no-shows with alternative scheduling and other supports, e.g. "go to the back of the line" after no-shows to regain clinic appointments. He stated there must be a full scope of support services (transportation, childcare, etc.) to assist workers in our current work economy. K Perry described standby scheduling which has reduced no-shows and late cancellations for the dentist in her facility, but there is still a higher no-show rate for hygiene appointments. L Beaudoin asked if we know what the no-show rate is for private pay or commercially insured patients. E Bodwell commented that if administrative burden, transport, etc. are addressed, specialists will enroll. S Iacopino stated that peer-to-peer discussions lead to network development.

S Finne described new MCO contracts include monthly reporting of data for children up to age 21 about missed/cancelled appointments and lack of oral health care for greater than nine months, so that care management can include the message of the importance of oral health in overall health. The MCO can also determine if there are other factors involved that are decreasing utilization of dental care. L Beaudoin asked about the effectiveness of the nine-month letter sent to parents. K Blackwelder reinforced the need for audits to be performed by peers, that training opportunities exist to educate ED staff about oral health, and that area agencies could assist in community health worker or other care coordinator training. She stated that the lack of enrolled oral surgeons is a crisis. S Finne described the Iowa dental benefit that has comprehensive level for the first year, which continues if the member has the correct number of preventive services. If the member does not meet that requirement, they then have a lesser benefit the following year. Questions arose about the specifics, and additional information will be provided at a later time. Sen. Rosenwald mentioned that the Legislature specifically prohibits punitive action against members. We need to keep this in mind when looking at a plan like Iowa has. Discussion of Vermont Dental voucher, which has worked well in the past, but it is uncertain how that will change with the recent increase in the yearly maximum allowed in Vermont.

5. The public health network of FQHCs/Community Health Centers/Non-profits cannot support this population alone. It is vital to have participation from private practitioners.

   Discussion: K Blackwelder and G Brown reiterated that FQHCs / CHCs/non-profits cannot handle the increased demand when the adult benefit is implemented.

   J Fitzgerald discussed the ways that mobile services and the use of alternate care delivery locations could help to provide an adequate network, including the use of tele-dentistry. Diagnostic and treatment planning components, as well as preventive services could be achieved in these locations, with referral for more extensive services when necessary. Dr. Finne presented information on behalf of Dr. Dan Kana from his many years of experience with Northeast Mobile Services. The key points were that an increased emphasis on preventive services is needed, a better referral network for oral surgeons to perform desperately needed extractions, understanding that the vast majority of these patients do not need dentures but

might require denture repairs, and that certified public health dental hygienists are the perfect provider to care for patients in this setting. If reimbursement is adequate and more frequent prevention is covered, dental care in this setting could focus on stopping active decay and preventing ongoing decay and infection.

General Discussion:
S Iacopino reminded the group that we need to maximize the FMAP (federal match) for our covered population, and that such things as cell phones provided by the MCOs can be a member support for the use of text messaging for appointment reminders.

G Brown commented that our workforce is critically important to a functioning network and that the workforce needs a good foundation and continuity in training. Medicaid members as a whole are a special population and the workforce must be able to deal with that.

Sen. Rosenwald raised her concern about the cost of the benefit and cautioned that we must be careful not to claim that there will be cost decreases over time. Budget cycles are only two years and cost savings will not necessarily fit within our biennial budget cycles. She asked if we could do a pilot with a sequenced addition of population groups into the benefit. This would require a waiver that could hinder meeting the implementation date of 4/1/21.

L Beaudoin asked how to assure that dentists get the education they need to treat adults with disabilities of varying degrees. Discussion of how to accomplish this included evaluating the training and making sure training is available statewide. She said we need layering of education about the new benefit with members, dentists, medical professionals.

L Dillon stated that the Oral Health Program (OHP) does outreach in a number of ways, including along with the NH Oral Health Coalition. There are also OHP funds specifically targeting oral health communication to the public. School-based programs are tied closely to school administrators. K Perry said the CPHDH from Mid-State works closely with school nurses. These are all ways that the public receives oral health messaging and help to spread a consistent message from a number of sources.

E Shanshala mentioned the Business and Industry Association (BIA) as a “partner” in messaging.

G Brown described a project for CIGNA employees that the Coalition designed. Employees are paid to attend health education on a monthly basis and NHOHC provided training for one major employer in 3 states. The biggest question shared by employees: Why didn’t I know all this info about oral health?