

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

December 19, 2019

Minutes

Working Group Members Present: Henry Lipman, Dr. Sarah Finne, Mike Auerbach, Dr. Kristine Blackwelder, Rep. Jennifer Bernet, Holly Eaton, Joan Fitzgerald, Amy Girouard, Shirley Iacopino, Dr. Daniel Kana, Courtney Morin, Dr. Kelly Perry, Sen. Cindy Rosenwald, Alexandra Sosnowski, Kristine Stoddard, Helen Taft, Nicole Tower, and Scott Westover.

Working Group Members Attending by Phone: Lisa Beaudoin, Gail Brown, Laural Dillon, Chris Kennedy, Janet Laatsch, and Rep. Mark Pearson.

Dr. Sarah Finne (Medicaid Dental Director) opened the meeting noting that the meeting would focus on a presentation by the Department's actuary, Milliman. The [presentation](#) is available on the HB 4 Working Group Webpage.

Joanne Fontana, FSA MAAA, is a principal and consulting actuary for Milliman. She has worked primarily with dental over the past 12 years. She works with a broad spectrum of clients including provider groups, dental carriers, the ADA, and the National Association of Dental Plans. She was joined by her colleague Mathieu Doucet, FSA MAAA.

Milliman is contracted by the Department of Health and Human Services (DHHS) as an actuary. Milliman was asked to provide today's presentation to support the decision-making process of the HB 4 Working Group. Milliman is not making any specific recommendations, but is sharing the results of their research and providing calculations of estimated costs. The presentation covers:

- 1) Comparison of NH's current Medicaid dental program to national benchmarks
- 2) Other states' approaches to Medicaid dental benefits (environmental scan)
- 3) Carve-in and carve-out — considerations and benefits for either model
- 4) Estimated adult dental program costs under various assumed benefit levels
- 5) Success factors and program innovations (other things to consider)
- 6) Other New Hampshire specific program considerations
 - Value-based care, and discussion on the NH child dental program that is fee for service (FFS) and the pros and cons of moving it into managed care.

1) New Hampshire Comparison to National Benchmarks

- Medicaid Child Dental Utilization (*see slides 5-6*)
 - Key consideration: although Medicaid child dental utilization is good — 7th in the nation and above the national Medicaid average, the data reveals a gap between Medicaid utilization and that of the commercially insured population which indicates that there is room to improve (e.g. 29 states have a smaller gap between child Medicaid and commercially insured utilization).
- Adult Dental National Benchmarks — 2013 ADA study (*see slide 7*)

- Key considerations: for states that had an adult dental benefit, the average utilization was 22.3%, and the best utilization rate was about 40%. The utilization gap between commercially insured and Medicaid populations is larger in adult dental populations.
- Provider Participation and Reimbursement (*see slide 8*)
 - Key consideration: there is a weak positive correlation between low provider participation and low reimbursement rates. Reimbursement at a fair level is important and necessary to participation, but it is not sufficient to make a program succeed; it is just one piece of the puzzle.

Michael Auerbach commented that NH dentists do not necessarily register with the Insure Kids Now (IKN) Website, so they would not be represented in the data.

2) Other states' approaches to Medicaid dental benefits (*see slides 10-11*)

All data is not corroborated and was obtained from public sources. Milliman looked at all states with an adult benefit in place that was more than emergency only.

Definitions:

Limited benefit - has 100 or fewer procedure codes often with a cap on annual spending and may not cover higher order services such as dentures.

Extensive benefit - covers a broad range of services and less likely to have any kind of spending cap.

Administrative models - indicates the type of state-run administrative model whether it is fee for service, third party ASO, carve-in or carve-out ; some states use multiple approaches. More than half the states do not have a cap. Most states don't require member cost sharing, but there are a few that use a point of service copay or nominal monthly pay-in (*see slide 11*).

Service categories * Gray lines indicate a lack of information

- Preventive (cleanings, oral exams)
- Diagnostic (X-rays)
- Endodontics (root canal)
- Periodontics (gum disease)
- Oral surgery
- Prosthodontics (dentures, tooth replacement)

Michael Auerbach asked if nutritional counseling is included. Dr. Finne clarified that the ADA has assigned a code which places it in the preventive category, but this coverage would have to be specifically included in a state plan. MSDA (Medicaid, Medicare, Chip Services Dental Association) has this information on state codes.

- Discussion on non-traditional state program characteristics (*see slide 11*)
 - Iowa (2.0 version) offers a full benefit year 1, but second year benefits can be reduced if enrollees don't follow a designated roadmap of behaviors. Sarah Finne will upload the Iowa Roadmap to the HB 4 Website.
 - Rhode Island is moving its children from FFS to managed care but are transitioning by letting the child age-out.

- Vermont is a state-owned MCO. VT increased the cap to \$1,000 annually and exempted preventive services from being counted toward the cap.
- Sarah Finne noted that Louisiana is having trouble maintaining a sufficient network.

3) Carve-in and Carve-out (*slides 12-14*)

Key consideration: priorities of the state’s dental program must be considered within the “entire” Medicaid program.

- Carve-in model: it is important to establish a dental capitation rate that is actuarially sound on its own with established dental-specific metrics. Carve-in models have a theoretical advantage for dental and medical integration that can include dental metrics in the patient’s medical record.
- Carve-out model: there are ways contractually to incentivize integration and to operationalize partnerships with the MCOs within the state.
 - With a single dental administrator, provider administrative burden is less cumbersome, and the vendor can focus solely on dental.
- Whether carve-in or carve-out, from a provider perspective, streamlining the administrative process is important to building a network.
- Administrative Services Only arrangement is where the state pays a vendor to perform particular administrative services related to the dental benefit. Could be an incremental approach toward a true managed care benefit while testing value-based care.

Gail Brown pointed out the importance of developing the initial network.

Lisa Beaudoin asked for more information on an adaptive model of an Administrative Services Only arrangement where the providers hold the benefit with the administration contracted out like in Connecticut and Maryland. Connecticut’s DSO is owned by dentists and they are integrated into the process. She suggested that the NH Dental Society and NH Dental Hygienists Association look into this type of model.

Dr. Sarah Finne added that Connecticut has a heavy emphasis on provider support with regional provider support representatives.

Henry Lipman asked Joanne Fontana for data on Connecticut in comparison to New Hampshire; but she was unable to provide the data on the spot.

Courtney Morin clarified that the question was mixing value-based payment models with funding methods. With an ASO the state would take on the risk. With a value-based model the dentists would have to eventually take on some of the risk.

Senator Cindy Rosenwald confirmed when asked by Henry Lipman, that the Legislature would be cautious and look for some predictability on costs.

Sarah Finne acknowledged that moving to value-based is a serious paradigm shift which requires a lot of consideration.

Kristine Blackwelder commented that the adult Medicaid population has not been provided dental services in a decade, and there is pent-up demand. An ASO would need to be at zero risk.

Scott Westover added that AmeriHealth Caritas's self-funded adult dental benefit is evolutionary, an investment to achieve health status improvement. Maybe with 1 in 5 AmeriHealth Caritas adults using the dental benefit, some of the deferred need will be mitigated. If successful in establishing programmatic efficacies and analysis on how the benefit impacts the total medical spend, there may be room for a conversation with the dental community to talk about increasing risk.

Michael Auerbach commented that the majority of children seen by private dentists taking Medicaid are seen by relatively few dentists. Those dentists may be able to take a few more including adults, but recruiting new dentists to the program will be difficult.

Sarah Finne stated that there is not a direct correlation between dentists who take children in Medicaid and those who might take adults because there are large providers who are strictly pediatric dentists.

Helen Taft pointed out that the adult benefit will put a strain on FQHC dentists who already take Medicaid.

Kristine Stoddard pointed out that there is need to change reimbursement rates to other (non-dentist) dental team members.

Joan Fitzgerald indicated that some of the built-up demand can be met by utilizing Certified Public Health Dental Hygienists at the top of their scope of practice.

Sarah Finne concurred that there needs to be an additional provider type in the program and that these type of conversations will continue.

Kelly Perry was encouraged by the results of the survey of dentists. Dentists who don't see children and don't take Medicaid now because of the emergency nature of the current adult benefit and lack of benefit resources for follow-up treatment may be enticed to take Medicaid by a reasonable comprehensive dental benefit and reimbursement rate. There will be a need to educate dentists about Medicaid and wrap-around services that maybe available.

Janet Laatsch added that 32% of their patients (Greater Seacoast Community Health) are adults, and they care for them regardless of their ability to pay. FQHCs are paid differently for medical, but for dental they only receive FFS. It would require a state plan change to pay the extended dental rate to FQHC.

Helen Taft provided historical information on DHHS' decision to implement a fee for service payment model for children and not implement an FQHC extended dental rate which resulted in FQHC dentists receiving the same payment as private dentists.

Gail Brown commented that FQHCs are a critical component of the network, but there are only 6 with dental centers.

4) Program Cost Estimates (see slide 16)

- Key considerations: Milliman provided cost estimates for low, moderate and comprehensive benefit levels based on programs in other states. They used a proprietary cost model tool designed for commercial insurance but modified for Medicaid including NH Medicaid population demographics. It was pointed out that the population number of 73,000 may be too low and

doesn't account for pent-up demand. The fee schedule includes the 3.1% reimbursement increase, but if reimbursement is increased beyond that, the numbers will increase. These numbers are adjustable based on the procedures included, and the reimbursement rate. The estimates aligned well with those previously provided by Northeast Delta Dental.

- New Hampshire ED Usage for Dental Diagnoses (*see slide 17*)

Key Consideration: Milliman used 2017 to 2018 Medicaid claims data for ED usage filtered on adults with the first ICD 10 diagnosis code being dental related. The PMPM also includes the pharmacy cost associated with the dental visit. Milliman did not exclude the Premium Assistance Program but adjusted the unit cost. The analysis lists \$1.75 PMPM which is high compared with other states. Studies from other states, even those with no adult dental benefit, have an average ED cost of \$4-5 PMPM annually. Instituting an adult Medicaid dental benefit will not eliminate all ED dental visits. An ADA study showed that about 21% of dental visits to the ED will still end up in the ED. The Milliman model shows a reduction of 10% - 40% in ED costs.

Sarah Finne commented that ED costs could be high because New Hampshire has never had an adult dental benefit, and there is a lack of oral surgeons in the state's dental network. There are patients who need to go to the ED because they need to be admitted to the hospital. There is no consistent protocol across the state on what to do when a tooth needs to be extracted. There are no dental residents in NH hospitals to perform oral surgery. Therefore current ED treatment with antibiotics for infection and pain treatment doesn't fix the underlying dental problem. We need to look at who is being seen in the ED and why.

Henry Lipman pointed out that the NH Department of Insurance reports that NH Medicaid ED utilization on the whole is lower compared to Medicaid ED usage in other states, so this analysis indicates that there is a concentration of ED utilization for dental.

Helen Taft reported that Families First had an ED referral program for same day dental treatment, but only 50% of patients chose follow-up treatment.

5) Other Program Success Factors and Program Innovations (*see slide 19*)

Milliman used a 2011 CMS study of 8 states that were successful in improving Medicaid dental utilization.

6) Other New Hampshire Specific Program Considerations (*see slide 22*)

- Value-based Care (*see slides 23-24*)

VBC in Medicaid dental is still an emerging concept.

Sarah Finne informed the group that NH is working on a value-based payment project with technical support from CMS to deliver dental services to 0 to 5 year-old children at WIC locations using bundle payments. The project is a cautious toe in the water on value-based payment. The idea is to make the project more sustainable with billing going through CHAP.

Cindy Rosenwald asked Joanne Fontana if she had any experience with the relative value of incentives or disincentives being on the patient versus being placed on the provider to get patients to follow-up on care plans. NH considers punitive approaches inconsistent with state policy. Joanne will look for research on whether incentivizing providers or consumers is more productive.

Sarah Finne commented that in general there needs to be increased dental education for the public; a need to create “buzz” that there is a serious health benefit to taking care of your mouth. Public education is part of the MCO contract.

Joan Fitzgerald commented that there needs to be behavioral support for consumers, particularly those in the special needs population. Integrated care models with care coordination is key to getting many in for dental help.

Kelly Perry asked *Joanne Fontana* if she could look at Medicaid data to identify dental issues being seen in primary care.

Joanne Fontana stated that “soft savings” (e.g. fewer low weight babies, improved diabetes rates) are difficult to document because correlation is documented by cause and effect and there is an absence of dental data. Some states have decided to take a leap of faith and implement diabetes related dental programs. Milliman did a Medicaid dental study for the DentaQuest Foundation to show insurers potential health care savings if dental services reduced chronic care costs even by a very small percentage.

Kelly Perry asked for information on the metrics being used in value-based care and who is responsible for collecting the data. What is the burden on providers?

Joanne Fontana responded that there are no overarching value-based programs; most states are implementing value-based pilot projects.

Sarah Finne suggested looking at Michigan’s value-based project. She went on to say that NH would not implement value-based metrics that are not typically used in the industry.

Courtney Morin stated that DentaQuest would be a source for value-based metrics.

Housekeeping:

- The meeting time has been changed from 4 to 6pm.
- The meeting location has been changed to the Brown building.
- A two-week meeting schedule will continue but because of the holidays, 2020 meetings will begin on January 16.
- Henry Lipman and Sarah Finne will submit a report in January indicating what changes to state law must be made; the changes made with HB4 (removing the prohibition to a dental benefit) is the only change needed.
- Henry Lipman discussed the process needed to get the dental benefit in place. The process will involve at least two legislative committees, the Joint Healthcare Reform Committee and the Fiscal Committee. He will obtain further information on the formal process. The hopes are to have everything mapped out by July so that the benefit can be included in the Governor’s budget.
- Senator Cindy Rosenthal wants to have discussions with the Finance Committee as well as legislative leadership.

Adjourn at 4 pm.