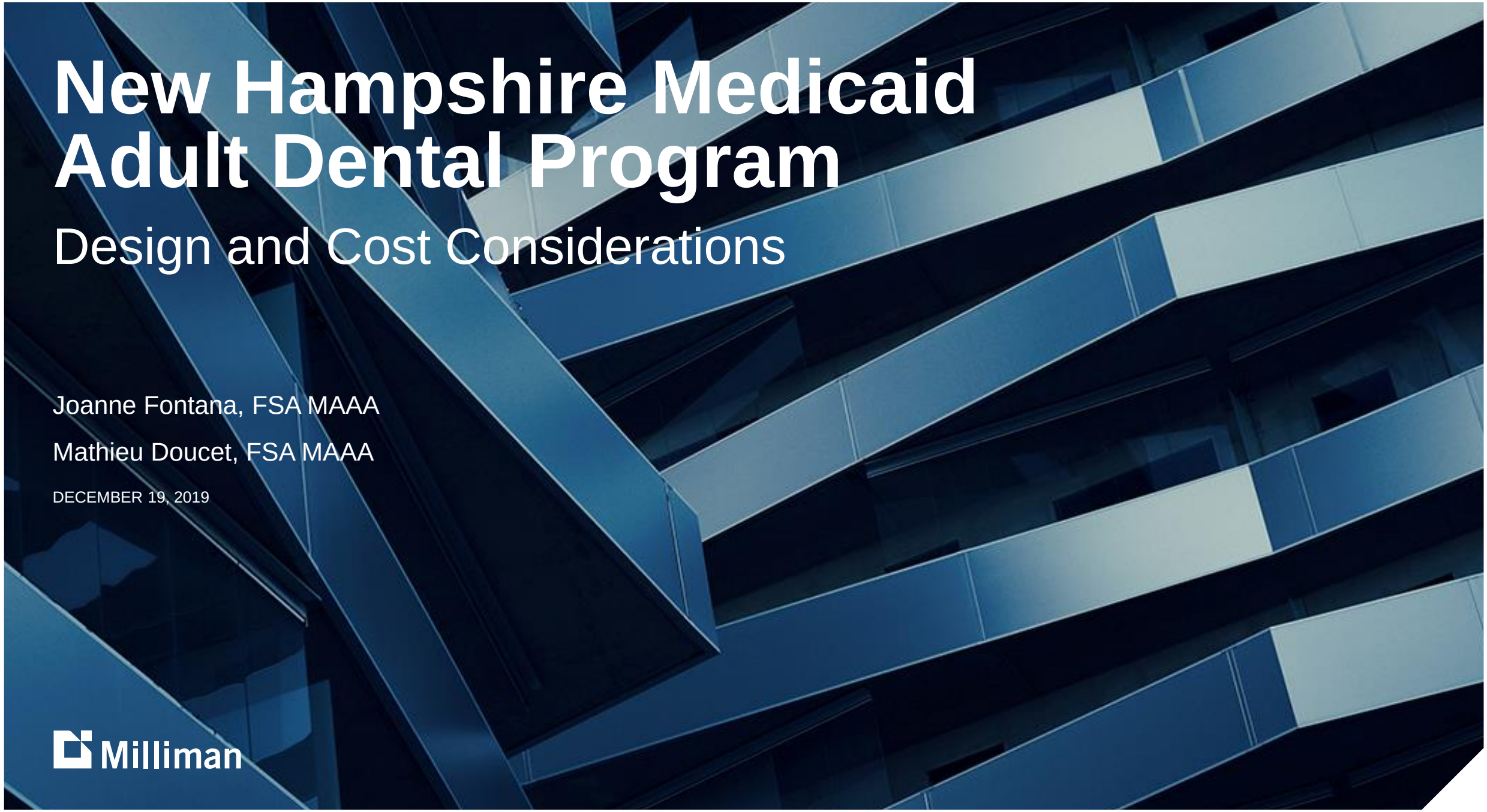

New Hampshire Medicaid Adult Dental Program

Design and Cost Considerations

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Milliman

Discussion Topics

1. New Hampshire Medicaid dental program comparison to national benchmarks
2. Other states' approaches to Medicaid dental benefits
3. Carve-in and carve-out considerations
4. Estimated adult dental program costs under various benefit levels
5. Success factors and program innovations
6. Other New Hampshire program considerations

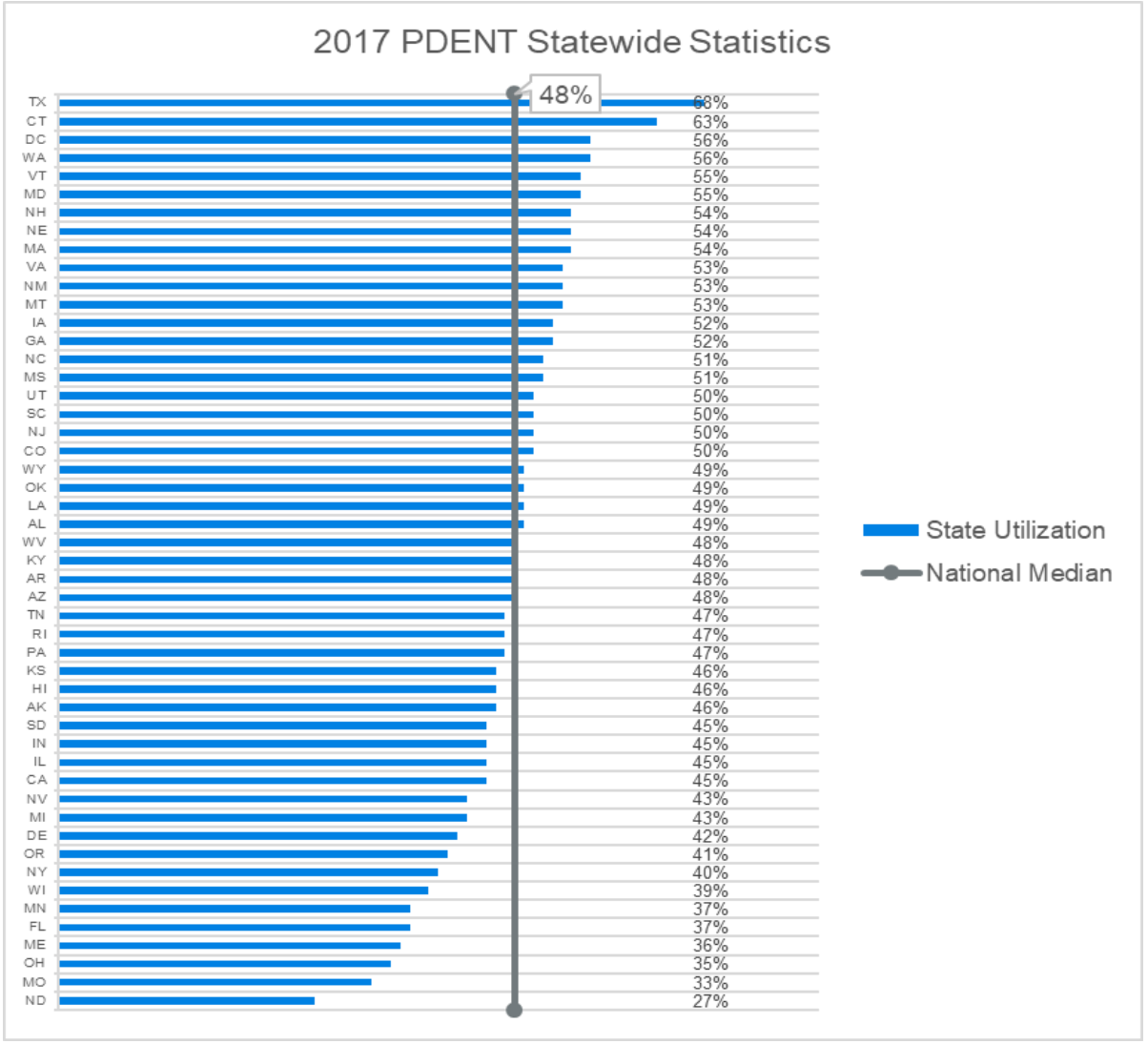
Comparison of Current Program to National Benchmarks

New Hampshire Medicaid Dental Program: Current State

- Child dental benefit administered by state on fee-for-service (FFS) basis
- Medical program administered by 3 MCOs: AmeriHealth Caritas of New Hampshire, Well Sense Health Plan, and New Hampshire Healthy Families
- Adult dental benefit is currently emergency only
- AmeriHealth Caritas began voluntarily offering value-added adult dental benefit in September 2019
- HB 4 instructs Department of Health and Human Services to prepare a plan for incorporation of adult dental benefit into state Medicaid program for 4/1/2021

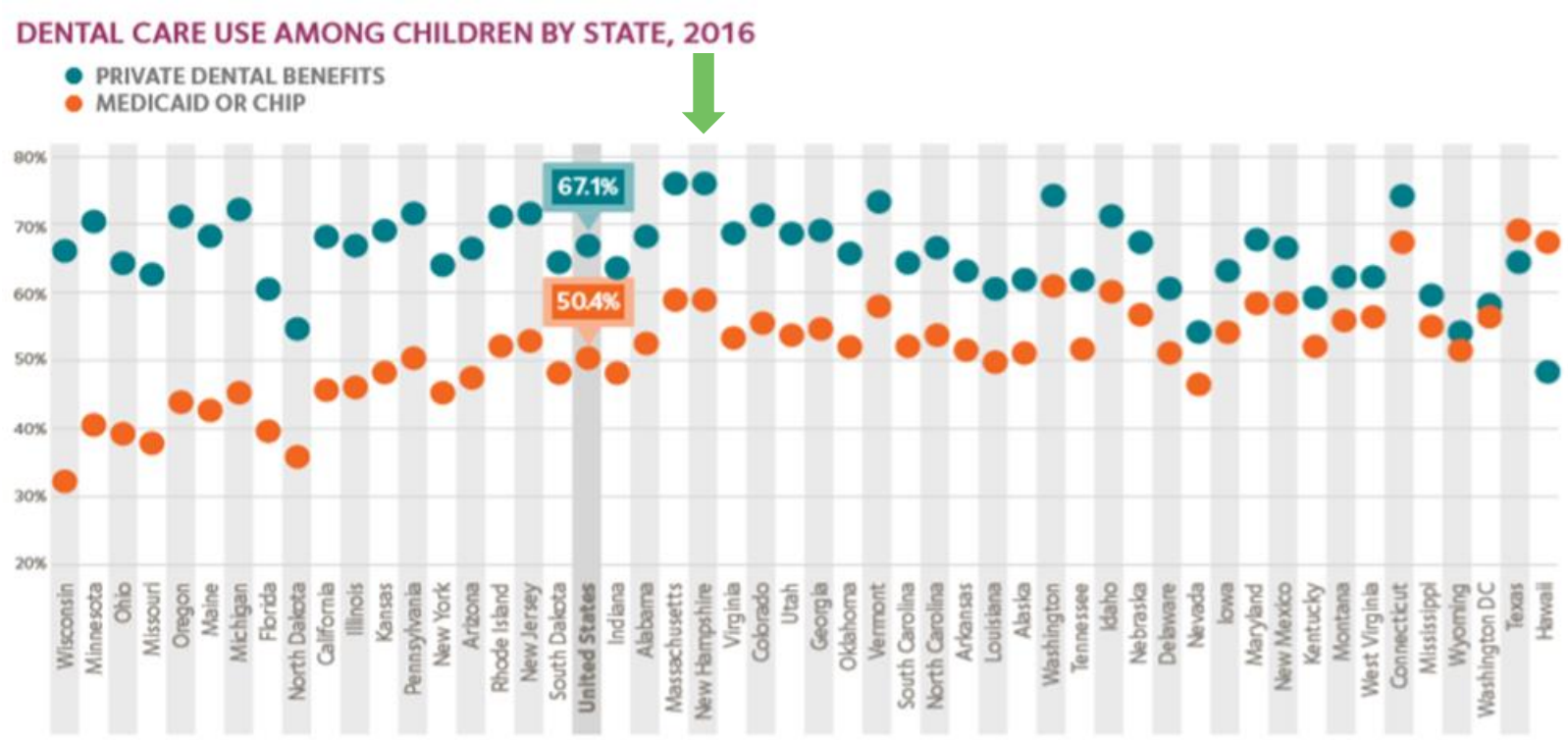
Comparison to National Benchmarks:
Medicaid Child Dental Utilization

- New Hampshire ranks 7th in nation for child Medicaid preventive utilization
- 54% of children received at least one preventive dental service in 2017 compared with national median of 48%



Comparison to National Benchmarks:
Child Dental Utilization Gap Medicaid v. Commercial (2016)

- Although raw NH child utilization is high, there is a relatively large utilization gap between Medicaid and commercially insured children
- National average gap 16.7%
- 29 states have smaller gap than NH



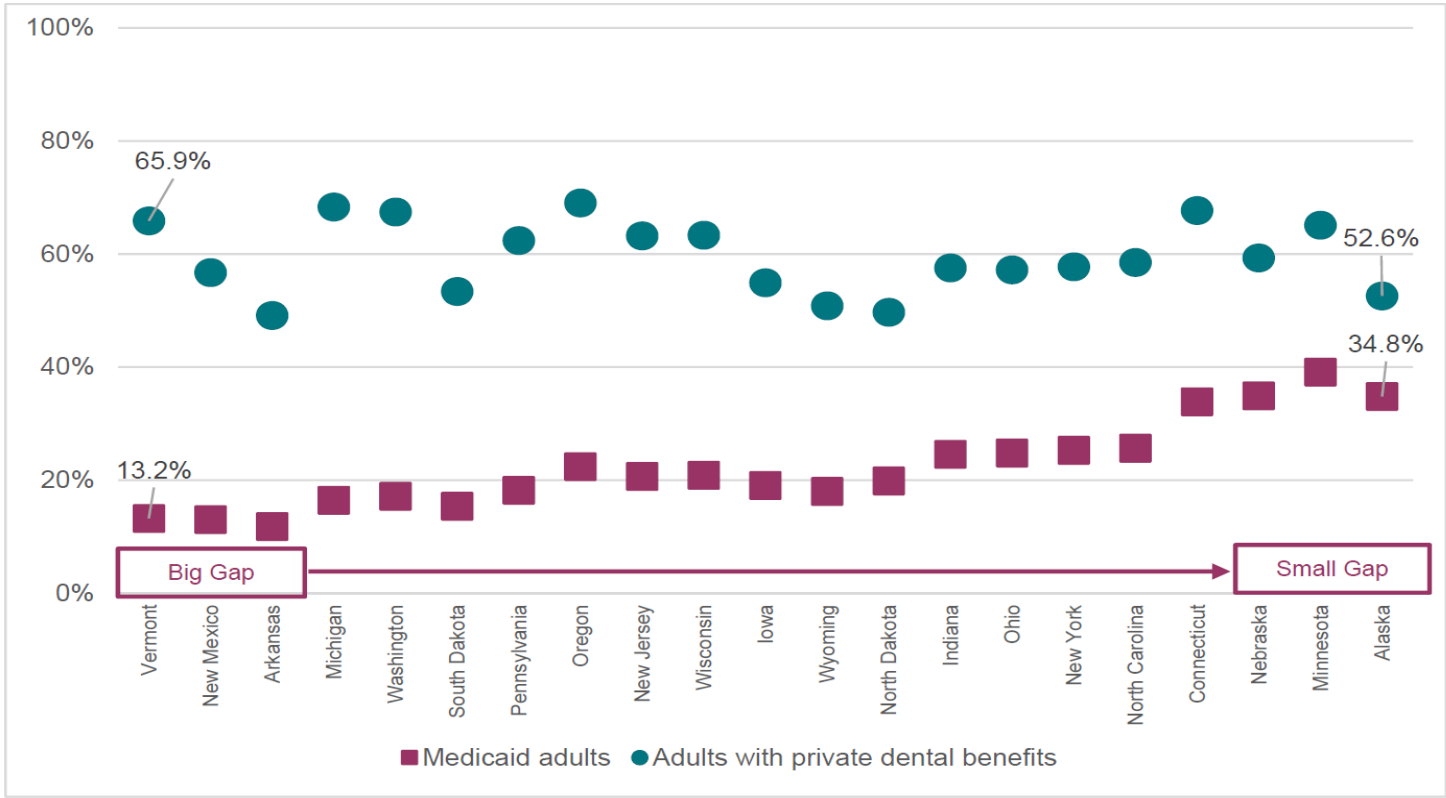
Data analysis and graphic design courtesy of the ADA Health Policy Institute

Reproduced from Dental Care Use Among Children: 2016. American Dental Association. https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0718_1.pdf?la=en. Accessed September 24, 2019.

Comparison to National Benchmarks:
Adult Dental Utilization (2013)

- For states that had a Medicaid adult dental benefit in 2013, average utilization was 22.3%
- Best in class utilization in 35 - 40% range
- Generally a wider gap between Medicaid and Commercial for adults than children

Figure 6: Relative Gap in Dental Care Utilization between Medicaid-Enrolled Adults and Adults with Private Dental Benefits, 2013



Source: HPI analysis of Truven Health Analytics MarketScan® Research Databases and Medicaid data from Medicaid Statistical Information System provided by CMS. **Notes:** States are ordered from left to right according to the relative gap between Medicaid-insured adults and adults with private dental benefits. Population is based on adults continuously enrolled in Medicaid or a private dental plan for 90 days. The states plotted provide adult Medicaid dental benefits.

Data analysis and graphic design courtesy of the ADA Health Policy Institute

Reproduced from Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrow, Remains Large for Adults. Vujicic, M and Nasseh, K. American Dental Association Health Policy Institute Research Brief, December 2015.

Comparison to National Benchmarks:
Provider Participation and Reimbursement

2015 Medicaid dentist participation

- National: 39%
- New Hampshire:16%
- New Hampshire 3rd to last nationally

2016 Medicaid dental reimbursement

- National: 61.8% of commercial
- New Hampshire: 51% of commercial

- Small positive correlation between Medicaid reimbursement and dentist participation
- Fair reimbursement is a necessary but not sufficient factor for program success

Data analysis and graphic design courtesy of the ADA Health Policy Institute

Reproduced from Medicaid Fee-for-Service (FFS) Reimbursement and Provider Participation for Dentists and Physicians in Every State. American Dental Association Health Policy Institute. 2016.

Other State Approaches to Medicaid Adult Dental

State Approaches to Medicaid Adult Dental

State	Benefit Structure				Services Covered					
	Benefit Level	Administration Model	Copay	Annual Cap	Preventive	Diagnostic	Endodontics	Periodontics	Oral Surgery	Prosthodontics
*Alaska**	Extensive	FFS	$3.00	$1,150	X	X	X			X
Arkansas	Limited	Carve-Out	None	$500	X	X		X	X	X
California	Extensive	FFS/Carve-In	None	$1,800	X	X	X	X	X	X
Colorado	Extensive	ASO	None	$1,500	X	X	X	X	X	X
Connecticut	Extensive	ASO	None	$1,000	X	X	X	X	X	X
*Hawaii***	Limited	FFS	None	None	X	X				
Idaho	Extensive	Carve-Out	None	None	X	X	X	X	X	X
Illinois	Extensive	Carve-In	None	None	X	X	X		X	X
Indiana	Limited	FFS/Carve-In	None	None	X	X		X		X
Iowa	Extensive	Carve-Out	None	$1,000	X	X	X	X	X	X
Kansas	Limited	Carve-In	None	$500	X	X				X
Kentucky	Limited	Carve-In	None	None	X	X				
Louisiana	Limited	Carve-In	None	$500	X	X				X
Massachusetts	Extensive	ASO	None	None	X	X			X	X
Michigan	Limited	Carve-In/FFS	None	None	X	X			X	X
Minnesota	Limited	Carve-In	$3.00	None	X	X	X	X	X	X
Missouri	Limited	FFS/Carve-In	None	None	X	X		X	X	
Montana	Extensive	FFS	$4.00/10%	$1,125	X	X				X
Nebraska	Limited	Carve-Out	$3.00	$750	X	X			X	X
New Jersey	Extensive	Carve-In	None	None	X	X	X	X	X	X
New Mexico	Extensive	FFS/Carve-In	None	None	X	X		X		X
New York	Extensive	Carve-In	None	None	X	X			X	X
North Carolina	Extensive	FFS	$1.00-$3.00	None	X	X		X	X	X
North Dakota	Extensive	FFS	$2.00	None	X	X	X	X		X
Ohio	Extensive	Carve-In	$3.00	None	X	X	X		X	
Oregon	Extensive	FFS/Carve-In	None	None	X	X	X	X	X	X
Pennsylvania	Limited	FFS	None	None						
Rhode Island	Extensive	FFS	None	None	X	X	X	X	X	X
South Carolina	Limited	ASO	$3.40	$750	X	X				
South Dakota	Limited	FFS	$3.00	$1,000	X	X	X		X	X
Vermont	Limited	Carve-In	$3.00	$510	X	X				
Virginia	Limited	ASO	None	None		X			X	
Washington	Extensive	FFS	None	None	X	X	X	X	X	X
Wisconsin	Extensive	FFS/Carve-In	None	None						
Wyoming	Limited	FFS	None	None	X	X		X	X	X

**Alaska's extensive benefit was available until 7/1/2019*

***Medicaid Benefit is Emergency Only, but value-added benefits are offered via MCOs*

= could not find information on benefits

State Approaches to Medicaid Adult Dental

Some non-traditional state program characteristics:

1. **Kentucky:** requires childless adults to share in the cost of dental care; can earn cost-share dollars by doing health, job, education, or community-related events
2. **Iowa:** if members do not meet certain health behavior criteria (e.g. preventive service use, oral health self-assessment), their dental benefit is reduced in year 2 of coverage
3. **Rhode Island:** adult dental is carve-in, child dental is FFS migrating to managed care
4. **Indiana**: adult dental services only offered in HIP Plus plan which requires members to make monthly contributions based on income
5. **Louisiana**: will be moving from carve-in to carve-out as of 7/1/2020
6. **Michigan**: traditional Medicaid dental is FFS, expansion is carve-in
7. **Vermont**: state-run dental MCO

Carve-In, Carve-Out, and ASO Arrangements

CATEGORY	CARVE-IN	CARVE-OUT
Priority of Dental Program	▪ MCOs may have incentive to prioritize medical over dental ▪ Contract should include dental-specific performance metrics and goals to ensure focus/measure program outcomes	▪ Sole focus on dental care ▪ Contract should include concrete performance metrics and goals to measure program outcomes
Integration of Dental and Medical Care	▪ Theoretical advantages: (1) better care integration; (2) direct acknowledgement of mouth/body connections in chronic disease; holistic member health history	▪ Less obvious opportunity for integration ▪ Contracts should incentivize and operationalize partnerships between MCOs and DMCOs
Administrative Ease for Providers	▪ MCOs could have different dental programs/subcontractors with different administrative requirements for providers ▪ If MCOs can streamline administration, could improve provider participation rates	▪ If single DMCO, then single administrator for providers ▪ If multiple DMCOs, could have different administrative requirements for providers ▪ If DMCOs can streamline administration, could improve provider participation rates
Beneficiary Understanding of Benefits	▪ Within an MCO, beneficiaries would have single administrator for medical and dental ▪ MCO can extend existing protocols for outreach, education, etc. ▪ Need to ensure these services specifically measured for dental as well as medical	▪ Beneficiaries would have separate administrator for medical and dental ▪ DMCOs have existing protocols for outreach, education, etc.

Carve-In, Carve-Out, and ASO Arrangements, continued

CATEGORY	CARVE-IN	CARVE-OUT
Value-based Payment Systems	▪ MCOs have expertise and experience in implementing value-based payment systems. ▪ Potential for integrated medical/dental VBP ▪ May have a more difficult time than DMCOs implementing dental-specific systems due to lack of dental expertise, but could devise systems that better integrate medical and dental outcomes.	▪ DMCOs have expertise and experience in implementing value-based payment systems. ▪ May be able to implement dental specific programs more easily due to dental focus and understanding of dental providers
Provider Network	▪ MCO has relationships with physicians, can leverage for better medical/dental integration ▪ MCO has network contracting specialists to grow dental network and manage provider relationships ▪ But may lack in-house dental focus and provider expertise	▪ DMCOs have relationships and dental provider contracts to grow dental network and manage provider relationships ▪ In-house dental focus and expertise ▪ No relationship with physicians to facilitate integration
Operational/ Administrative Efficiency of Program	▪ MCO has incentive to operate efficiently under capitation arrangement but may focus on medical over dental ▪ Include a dental specific capitation allotment in contract to maintain dental focus	▪ DMCO has incentive to operate efficiently under capitation arrangement ▪ Sole focus is on dental operations
Consulting Fees	▪ Actuarial consulting fees for program certification would be lower under carve-in arrangement since dental program integrated into medical ▪ Single procurement process for medical/dental combined	▪ Actuarial fees for dental program certification would be in addition to medical certification ▪ Dual procurements if dental is separate from medical

Carve-In, Carve-Out, and ASO Arrangements, continued

Comments on ASO Arrangement as Carve-In/Carve-Out Alternative:

- With FFS child dental benefit in place, ASO could improve upon administration of that benefit by taking advantage of Third Party Adminstrator's capabilities while implementing and developing experience with the adult benefit
- Could be an incremental step toward true managed care
  - Having utilization and cost experience under ASO arrangement could provide "peace of mind" to MCOs or DMCOs taking risk for a new program
- Could test value-based care via specific initiatives and/or "ASO plus risk sharing" model

Program Cost Estimates

Illustrative Cost Estimates for Sample Adult Dental Benefits

PLAN ELEMENT	LOW PLAN	MEDIUM PLAN	HIGH PLAN
Model State	Louisiana	Colorado	New Jersey
Annual Benefit Cap	$500	$1,500	No cap
Covered Services	Exams, cleanings, other preventive, fillings, extractions	Exams, cleanings, other preventive, restorative, endodontics, periodontics, oral surgery	Exams, cleanings, other preventive, restorative, crowns, root canals, periodontics, oral surgery, complete and partial dentures

Estimated Benefit Cost PMPM	$8.50	$ 12.25	$20.50
Annual Cost (Millions), @ 73,000 Lives	$7.4	$10.7	$18.0
State Portion of Cost (Millions)	*$2.3*	*$3.4*	*$5.6*
Federal Portion of Cost (Millions)	*$5.1*	*$7.4*	*$12.3*

* *Costs based on Milliman Health Cost Guidelines – Dental™, adjusted to reflect New Hampshire adult Medicaid demographics, Medicaid provider fees including HB4 prospective increases, and commercial-to-Medicaid utilization adjustments*
* *FMAP assumptions 50% traditional Medicaid and 90% expansion*
* *No explicit adjustments for pent-up demand, service mix shift over time, managed care initiatives, or additional unit cost changes*
* *Moving from Medicaid to commercial charges would almost double the costs shown here*

New Hampshire ED Usage for Dental Diagnoses

- Analyzed 2017-2018 emergency department (ED) usage by New Hampshire Medicaid adults
  - Excluded Premium Assistance Program experience
  - Included ED costs for which first indicated diagnosis code was dental-related ("K0" ICD-10 codes)
- **$1.75 PMPM x assumed 73,000 covered adults = $1.5M annual cost of Medicaid dental visits**
- But not all ED usage will be eliminated due to introduction of adult dental benefit
  - ADA statistic: 21.4% of dental ED visits could not be handled in dental office due to critical and immediate needs of patient
  - So even with a perfectly functioning dental program 21% of patients will still be treated in ED
  - ED savings will accrue over time as preventive coverage starts to affect oral health; not all immediate
- We modeled 10% - 40% reductions in ED dental visits by adult Medicaid population to estimate potential dental program cost offset

IF ADULT ED DENTAL VISITS ARE REDUCED BY:	10%	20%	30%	40%
Then potential program cost offsets are (in millions):	$0.15	$0.31	$0.46	$0.61

Other Program Success Factors

Other Program Success Factors

Provider Reimbursement	▪ Fair provider reimbursement is necessary but not sufficient to develop and maintain adequate provider network
Administrative Processes	▪ Easy for providers (credentialing, claims submission and payment, prior authorization, support for missed appointments)
Education and Outreach	▪ Inform adults and families of benefit and importance of using benefit ▪ Involve dentists, primary care doctors, ED personnel, community organizations
Transportation	▪ Even with transportation benefit, beneficiaries can struggle to get to appointment ▪ Improve convenience/timeliness of transportation services
Community-Based Care	▪ Allow beneficiaries to access dental care in school/work/community health centers ▪ Teledentistry and/or certified public health hygienists can play role
Other	▪ Dental program champion ▪ Partnering with state dental education programs

Based on multiple sources including Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports: (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia). Centers for Medicaid and Medicare Services, January 2011.

Innovative Approaches

Dental Therapists/Certified Public Health Hygienists	▪ Mid-level dental providers can fill gaps in rural areas or areas with insufficient number of dentists to perform some dental services ▪ New Hampshire uses certified public health hygienists in this manner
Teledentistry	▪ Some states actively using teledentistry to improve access in remote/underserved areas ▪ California Virtual Dental Home ▪ Can incorporate certified public health hygienists into teledentistry efforts

Based on multiple sources including Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports: (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia). Centers for Medicaid and Medicare Services, January 2011.

Considerations Specific to New Hampshire Implementation

Coordination with Child Medicaid Dental Program

Child dental program is currently administered FFS by state; what are the pros and cons of combining child program into adult implementation?

Fully integrate child and adult programs	Keep FFS child program separate	Staged integration of child and adult programs
▪ Increased managed care membership provides leverage for MCO/DMCO contracting and administrative cost spreading	▪ Minimize disruption to child dental care	▪ Predefined staging may help achieve some advantages of integration while managing potential pitfalls
▪ Single dental program for all family members	▪ Focus efforts solely on implementation of adult benefit	▪ Can customize staged approach to meet state goals (e.g. by region, by subgroup of children, age-in, etc.)
▪ Single dental program for providers to manage	▪ Lower membership leverage for MCO/DMCO contracting and administrative cost spreading	▪ May be confusing/burdensome for providers
▪ Program outreach efficiencies	▪ Separate programs may be confusing for families	▪ Disparate programs for different family members and over time could be confusing to beneficiaries
▪ Potential disruption in child dental care	▪ Separate programs may be confusing to providers	▪ Significant education/outreach
▪ Large scale change for state to manage	▪ Potentially duplicative outreach/education	

Value-Based Care (VBC)

- Law authorizing adult dental benefit requires value-based platform, with legislative intent of providing value, quality, efficiency, innovation, and savings
- Will likely be up to contracted dental vendors to demonstrate how concepts will be applied to produce cost efficiencies and positive dental health outcomes
- VBC use in Medicaid dental programs emerging; results still developing
  - CA Dental Transformation Initiative: incentive payments to dental offices meeting Medicaid preventive service increase thresholds
  - OH episode of care payment model for extractions; rewards based on cost and quality outcomes
  - FL capitation withhold to DMCOs, return tied to meeting CMS PDENT/TDENT measures
  - Medicaid Innovation Accelerator Program Value-Based Payment and Financial Simulations Technical Support Program: used by Washington DC, Michigan, New Hampshire
  - NH's program experiments with co-delivery of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and oral health services in the same setting

Value-Based Care (VBC), continued

Medicaid Innovation Accelerator Program Webinar, August 2019

Themes in implementing VBC approaches include:

1. the implementation process is iterative, with consistent evaluation and re-evaluation;
2. data infrastructure is critical to ensure capture of the appropriate benchmarks and measurement against those standards; and
3. engagement and alignment of policyholders, payers, clinicians, and other stakeholders is vital to success.

Survey of states indicated that:

- 15% of states are working on designing Medicaid dental value-based programs
- Another 35% are not yet considering but are interested in the concept

Caveats and Limitations

- This document is intended to be used by DHHS to summarize design and cost considerations for the adult dental benefit. This information may not be appropriate for other purposes.
- This information should not be relied upon by anyone other than DHHS. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This information assumes the reader is familiar with the New Hampshire Medicaid program.
- In preparing this document, we relied on information provided by DHHS. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.
- The results presented herein are estimates based on carefully constructed actuarial models. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.
- This presentation and its use is subject to the contract between DHHS and Milliman effective on July 1, 2017.
- We, Joanne Fontana, FSA, MAAA and Mathieu Doucet, FSA, MAAA are Consulting Actuaries for Milliman. We are members of the American Academy of Actuaries and we meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

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Thank you

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