CMS Sufficiency ARA memo, 12-16-2014

1) **BACKGROUND.** What is the reason for this limitation? If the reason for the limitation is duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes have you tried or considered to address this matter?

   State response: The NH Medicaid dental program has only provided emergency dental services to adult beneficiaries. Legislation was necessary to include preventive, restorative, limited periodontic, and oral surgery services. The $1,500/year limitation, which excludes preventive services, was included in the legislation that was signed into law on July 1, 2022.

2) **PURPOSE.** (specific to optional services). What is the clinical purpose of this benefit and will that purpose be achieved even with this limit?

   State response: The clinical purpose for this benefit is to improve oral health and general health through increased access to dental services. The current emergency adult dental benefit covers limited exams, radiographs and other imaging, and extractions. The new adult dental benefit will include preventive, limited periodontic, restorative, and oral surgery services. The added dental services will support prevention of oral diseases, restoration of currently diseased teeth, and extraction of non-restorable teeth. Dental providers have experience with treatment planning under yearly limits and design treatment plans to address the most serious dental issues immediately. Restorative care continues until limits have been met. Preventive services are excluded from the yearly limit, allowing beneficiaries to continue to receive needed preventive services while waiting for the next coverage year to begin. This mirrors the dental services delivery to commercially insured individuals.

   An adult dental benefit workgroup that included dental providers, the New Hampshire Dental Society, the New Hampshire Oral Health Coalition, Waiver Community representatives, and other oral health stakeholders from across the state worked for 18 months to develop a benefit design that would meet the needs of adults who previously only had access to emergency services. There was agreement that this limit would not negatively impact the ability to improve oral health for adults covered by this benefit.

3) **DATA SUPPORT- New.** Using claims data within the last 12 months, what percentage of Medicaid beneficiaries who need services included under the benefit would be fully served (i.e., receive all the services they require) under the new limit? For optional services, the question becomes for what percentage of those served would the intended purpose described above be achieved? Please provide this information for the following eligibility groups:
   a. Aged, Blind and Disabled
   b. Non-Dually Eligible Adults (for analyses of services for which Medicare would not be primary payer, otherwise the analysis would include dually-eligible individuals)
   c. Pregnant Women
   d. Parents/Caretakers /Other Non-Disabled Adults
   e. Adult expansion group, if applicable; limitations may not circumvent the floor of coverage for Essential Health Benefits (EHBs) as articulated in the commercial plan defining EHBs.

   State response: This is a completely new benefit and the state does not have any previous claims data. Estimates of utilization of the adult dental benefit were prepared by actuaries and based on the services covered and the $1,500 yearly limit with preventive services excluded from that limit.

4) **DATA SUPPORT- Existing.** With respect to existing limitations and using data within the last 12 months, what percentage of Medicaid beneficiaries utilized the maximum amount of the service? Please provide this information for the following eligibility groups:
   a. Aged, Blind and Disabled

b. Non-Dually Eligible Adults (for analyses of services for which Medicare would not be primary payer, otherwise the analysis would include dually eligible individuals)
c. Pregnant Women
d. Parents/Caretakers /Other Non-Disabled Adults
e. Adult expansion group, if applicable

State response: N/A – new benefit; no past data.

5) **CLINICAL SUPPORT.** If the data requested above is not available, or is not relevant to demonstrating the sufficiency of the limited benefit, please indicate support for this proposed scope of services through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community or others that resulted in an assurance that this proposed scope of services has meaningful clinical merit to achieve its intended purpose.

State response: An adult dental benefit workgroup, including members as noted in question #2, worked for 18 months to develop a benefit design that would meet the needs of adults who previously only had access to emergency services. There was agreement that this limit would not negatively impact the ability to improve oral health for adults covered by this benefit.

6) **EXCEPTIONS.** Are there any exemptions to the proposed limitations? If so, how was this exemption determined to be appropriate? Does the state have a process for granting other exemptions if similar circumstances warrant? (e.g., if there is an exemption for individuals with one condition because their needs are greater, is there a process for other individuals with conditions that result in greater needs to request an exemption?) Can additional services beyond the proposed limit be provided based on a determination of medical necessity? That is, will there be an exception or prior authorization process for beneficiaries that require services beyond the limitation?

State response: There are no exemptions to the proposed limitations. An adult dental benefit workgroup, including members as noted in question #2, worked for 18 months to develop a benefit design that would meet the needs of adults who previously only had access to emergency services. There was agreement that this limit would not negatively impact the ability to improve oral health for adults covered by this benefit. Dental providers felt that the design of the benefit with the exclusion of preventive services from the yearly $1500 limit met acceptable clinical practice guidelines.

7) **BENEFICIARY IMPACT.** Please describe what will or is likely to occur to beneficiaries who will be impacted by this limitation. If the limit cannot be exceeded based on a determination of medical necessity:
a. How will those affected by the limitation obtain the medical services they need beyond the stated limits?
b. Will beneficiaries be billed and expected to pay for any care that may not be covered? Or, instead will the provider or practitioner be expected to absorb the costs of the provided services?
c. Will beneficiaries be reassessed to determine need for the service prior to the plan amendment's effective date?
d. If the beneficiary's covered services are being reduced, will the beneficiary be notified of their appeals rights per 42 CFR 431.206?

State response:
a. In the case of accidental injury, medical insurance will cover those expenses. Routine dental care can be planned out and delivered within the yearly limit.
b. If the beneficiary chooses to have non-covered services, they will be billed for those services and expected to pay for them.

c. N/A.
d. N/A.

8) **DELIVERY SYSTEM.** Will the proposed limitation apply to services performed through managed care contracts, fee-for-service (FFS) or both? If applied in managed care, indicate whether or not the capitation rates will be adjusted to reflect the change.

State response: The proposed limitation will apply to services performed through a PAHP contract; capitation rates include the plan limit.

9) **IMPLEMENTATION.** How will the State be implementing the limit? For example, how will the State be publicizing this limit to beneficiaries and providers in a timely manner that allows decisions on the provision of care to be made in acknowledgement of the limit?

State response: There has been considerable press coverage of the legislative process, including the official signing ceremony that was held on July 1, 2022 in the Governor's office. There have been multiple articles in the local press (N.H. expands Medicaid dental benefits | New Hampshire Public Radio (nhpr.org), NH expands Medicaid to include dental benefits for adults (wmur.com) state has made this information available on its website, and the dental organization is responsible for informing providers and beneficiaries of plan limits as defined in their contract with the state. Beneficiaries are also automatically enrolled in this benefit.

10) **TRACKING.** How will the limitation be tracked? Will both providers and beneficiaries be informed in advance so they know they have reached the limit? Please summarize the process.

State response: The beneficiaries will be informed of covered services, including limits, in the following ways: a mandatory Welcome Call from the DO, information published on the DO website in the member services area, and in written publications. Likewise, the DO will furnish covered services and benefit limit information on their website in the provider services area.
The dental organization will also be responsible for tracking the individual beneficiary limit and informing both providers and beneficiaries as defined in the DO contract with the state.