

- I. Dr. Snow's point of view as NH Medicaid Dental Director:
  - a. Let's replicate for adults the model of success that NH Medicaid has demonstrated for children in Medicaid: TRIPLE access to care while increasing participating dentists by only 32%. Go with the model that is proven to work in our own state.
  - b. Be mindful of exactly the problems we are trying to solve
    - i. Understand what services are needed/demanded and ask if new provider types can meet this need?
    - ii. Develop programs, funding and recruitment of services that are known to be needed/demanded
      - 1. Support adult Medicaid benefit
      - 2. Support the improvement of Medicaid systems that make costs more predictable and sustainable while assuring quality
  - c. Capture the services that are needed at the least possible cost (i.e., capture existing capacity rather than create new programs that will need additional resources to administer, regulate and fund)
  - d. Carefully choose our path, as any one choice excludes ability and \$\$ to do others
- II. Goals
  - a. Goal of Medicaid: provide quality care at a predictable cost in a sustainable program aligned with regulatory environment.
  - b. Medicaid is important bcs
    - i. Is THE major provider of programs and payment for dental treatment of "underserved" populations in NH
    - ii. Usually looked to indirectly financially support public programs
    - iii. As a very large sector of state budget, small changes in policy can have huge fiscal impact, especially for entitlement-program beneficiaries
    - iv. Because Medicaid \$\$ are limited, important to consider the following:
      - 1. Fiscal impact of policy decisions
      - 2. Most efficient use of Medicaid \$\$s
      - 3. Opportunity costs of any decision, i.e., if you do one thing, there isn't going to be funding to do something else
- III. Children's Medicaid Dental Benefit Is a Model of Success in providing access to bona fide low income patients
  - a. Our experience over last 12 years shows that when reimbursement is adequate, administrative burden is low, and Medicaid patients are supported in overcoming barriers to care, we can provide access to dental care that is nearly equal with that of the insured.
  - b. NH Medicaid dental services are provided
    - i. in private dental offices, so our biggest safety net providers are private practitioners
    - ii. FQHCs
    - iii. Community programs
    - iv. School based and linked programs

- c. All dental services are fee for service. No managed care contracts for dental services
- IV. Challenges: Making sure “solutions” match existing demands
  - a. Supply
    - i. Most private dental offices, FQHC and community dental programs have excess capacity to supply:
      - 1. Preventive and routine treatment by appointment, with expectation of compliance
      - 2. There is currently excess capacity (supply) of general dentistry and most specialty services that can be captured if there were a means to pay for those services for bona fide low-income adults (Medicaid.)
      - 3. Constraints on supply
        - a. Expensive, so requires adequate reimbursement and high utilization of capacity (dental practices very sensitive to no-shows)
        - b. Administrative burden for claims, etc
        - c. Especially needed are specialists hardest to attract: pediatric dentists, oral surgeons, periodontists, endodontists, old school generalists who have experience to “do everything”
        - d. There’s no reimbursement for dental treatment for adults
        - e. Need case management to treat Medicaid patients just as others are treated (language, transportation, compliance, special health care needs, etc.)
  - b. Demand
    - i. Easiest to satisfy: Demand for preventive, routine treatment by appointment, those services adequately reimbursed by Medicaid or other third party payer
    - ii. Hardest to satisfy: emergency treatment, complicated and extensive treatment needed due to deferred care, unreimbursed care, specialty services such as oral surgery, root canals, and pediatric dentists, need for case management; treatment of people with special health care needs;
  - c. DHPSAs: do not reflect what we need to satisfy specific unmet needs, i.e., we need specialists, not just “dentists”.
  - d. ADA materials show that NH Medicaid has flagging Medicaid rates and lack of ability to compete with surrounding states, especially for oral surgeons, pediatric dentists, and other needed specialists
- V. Other States
  - a. MN and Alaska: Attached chart shows differences from NH in ability to support mid-level providers with clinical back up for treatment that exceeds that within the scope of the mid level; have much more extensive supervisory requirements and responsibilities of collaborative agreements; mid-levels limited to specific practice settings.