Comprehensive Dental Benefit for Medicaid Adults (Expansion Population)

• Delivery Models
  – MCO, ACO, Minimal FFS

• Benefits
  – Under the MCOs, ACOs and FFS

• Medical-Dental Integration
  – Varies depending upon the MCO
History of New Jersey Medicaid (Late 1960s)

- Program State-operated and administered
- One payer
- Any willing provider
- Enrollment based on income standards
- Bureau of Dental Services
NJ FamilyCare Program (2015)

- Multiple MCOs
- Multiple Payers
- Providers/networks
- Enrollment expanded to multiple FPL levels
- Integration models vary among MCOs:
  - All health care benefits through one MCO
  - Some MCOs subcontract with dental vendors
Program Benefits

• Medical
• Dental
• Transportation
• Dental integration in EPSDT program
• Supports innovative medical and dental models
Populations Enrolled

Prior to January 1, 2014
• Children
• Aged, Blind and Disabled
• Families

After January 1, 2014
• Children
• Aged, Blind and Disabled
• Families
• Single Adults and childless couples

Note: Includes all recipients eligible for NJ DMAHS programs at any point during the month
NJ FamilyCare Expansion Group Enrollment


Note: Includes all recipients eligible for NJ DMAHS programs at any point during the month. Expansion Group = ABP Parent Up To 133% FPL and ABP Other Adults Up To 133% FPL
Opportunities to Learn

• Apply lessons learned from FFS program
• Use member and focus group feedback
• Seek input from experts and advocates
• Better integrate oral health & primary care
• Evaluate the process for dental referrals
Opportunities through Contracting to Improve Program & Health Outcomes

- Define integrated care
- Indicate MCO staff requirements and their responsibilities
- Provider monitoring for quality and health outcomes
- Member outreach, education and care management
Reporting and Analysis

- CPT & CDT code systems
- Systems compatibility
- Reporting measures
- Diagnosis Codes
- Electronic Health Records
Changes Needed to Effectively Advance Medical & Dental Integration

• State
  – Effective contracting
  – Monitoring and managing

• MCO
  – Innovative implementation and programming
  – Working with network providers & members

• Providers
  – Awareness of dental benefit and scope of services
  – Effective communication & collaboration between healthcare providers
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2015 National Medicaid and CHIP Oral Health Symposium

Session 3

Reconnecting Mouth and Body...

...in the Policy World

Marko Vujicic, PhD

Washington Marriott Wardman Park, Washington DC

June 1, 2015
Implications of Being “Essential”

Figure. Percentages of low-income children and adults with a dental visit in the past year. Low income is defined as being at less than 100 percent of the federal poverty guidelines. Children are defined as being aged 2 through 18 years; adults are defined as being aged 19 through 64 years. Changes are significant at the 1 percent level (2000-2011). Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality.¹⁻¹²
Dental Care Utilization

Percent of Medicaid Children with a Dental Visit in the Past 12 Months, 2000 and 2013

Small Gains

Large Gains

43.0%

27.0%
Dental Benefits Coverage

Figure 1: Source of Dental Benefits, Children Ages 2-18, 2000-2012

Source: Medical Expenditure Panel Survey, AHRQ
Notes: All changes were significant at the 1% level (2000-2012). Changes from 2011 to 2012 were not statistically significant.
Integration via ACOs

Figure 1: Inclusion of Dental Services in Accountable Care Organization Contracts by Contract Type

Note: ACOs were asked about their responsibility for dental services in commercial contracts in both survey waves and in Medicaid contracts in the second wave. Payer categories are not mutually exclusive. An ACO may be held responsible for dental services by a commercial contract, a Medicaid contract, or both. Results presented are pooled across eligible ACOs (those with a commercial contract in either survey wave and those with a Medicaid contract in wave 2). ^For ACOs formed between September 2012 and July 2013.
Medicaid Expansion

8.3 million Medicaid Coverage

1.1 million Private Coverage
Reasons for Not Seeking Dental Care

**Figure 3:** Reasons Why Adults Do Not Plan to Visit a Dentist in the Next 12 Months by Health Insurance Status

Source: ADA Health Policy Institute analysis of Harris Poll survey data collected April 2014. Notes: Results based on 965 observations. Health insurance categories are based on respondents’ reported source of health insurance. All survey responses are weighted by general population weights provided by Harris Poll.
Rethink the Role of the Dentist

**Figure.** Visits to dentists and physicians in the course of one year among U.S. patients. Analysis by the American Dental Association Health Policy Resources Center, based on data from 2011 (the most recent year for which data are available) from the Medical Expenditure Panel Survey of the Agency for Healthcare Research and Quality.
Thank You!

For more information on the Health Policy Institute please visit:

ada.org/hpi

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