// State Legislative Report

News for Dental Leaders

April 2009

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"A man's country is not a certain area of land, of mountains, rivers, and woods, but it is a principle and patriotism is loyalty to that principle."
--George William Curtis

Editor's Note

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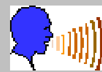

Sound Byte

Spending on health care and related activities will account for nearly18 percent of GDP in 2009—an expected total of $2.5 trillion—and under current policies, that share is projected to exceed 20 percent in 2018. Annual health expenditures per capita are projected to rise from about $8,000 to about $13,000 over that period. Federal spending accounts for roughly 1/3 of those totals, and federal outlays for the Medicare and Medicaid programs are projected to grow from about $720 billion in 2009 to about $1.4 trillion in 2019. Over the longer term, rising costs for health care represent the single greatest challenge to balancing the federal budget. *Source CBO Testimony before Subcommittee on Health; Committee on Energy and Commerce; U.S. House of Representatives. March 10, 2009*

Medicaid Update – Part Two

Last month we promised you more news on state Medicaid dental programs.

In the last issue, we reported cuts to the **South Carolina** adult dental Medicaid program. Just after we published, news came across that adult dental will be continued using federal stimulus dollars.

The budget plan for **Connecticut** is to eliminate most adult dental care in Medicaid. Governor Rell has proposed eliminating all but emergency dental coverage for adult Medicaid beneficiaries, which would save the state an estimated $50.7 million over two years. The Connecticut Dental Association is hoisting the loyal opposition to bills that would cut adult Medicaid down to emergency services only and require prior authorization.

Idaho Medicaid dental rates will hover at their current amounts until June 30th, 2010. Thereafter, the reimbursement rate will be adjusted each fiscal year using the inflation rate forecasted as of the midpoint of the fiscal year.

A bill in **Illinois** would prevent Medicaid dental service fees from being set lower than 64 percent of the reimbursement level that the state reimburses dentists under the State Employees Group Insurance Act. Another bill allows Medicaid dentists to participate in the health care provider deferred compensation plan.

A **Minnesota** plan would eliminate dental care for adults except for emergency dental care in hospital ERs effective January 1, 2010. The plan would also eliminate critical access payments for critical access dental care on July 1, 2009.

Nebraska is proposing a $1,000 cap on adult dental Medicaid. A proposal would allow the cap to be exceeded for certain treatment plans, such as dentures.

A **North Dakota** bill would reduce funding for adult Medicaid to 70 percent of average in 2008 with a 6 percent escalator in 2010.

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Oregon is proposing for the FY 2009-2011 budget to eliminate dental services in the Oregon Health Plan (Medicaid) for adults.**South Dakota** is proposing to eliminate adult dental in Medicaid this year.

The **Virginia** House, in its original budget, maintained the current payment structure for dental services in Medicaid. The Senate budget cut all provider groups, including dentists, by 3%. However, with the federal stimulus package, $808.2 million will be invested over the next two years maintaining dental Medicaid services at the current level.

The **Rhode Island** governor plans to eliminate dental coverage for about 38,000 low-income parents enrolled in RIte Care (RI's Medicaid program). The governor's office was quoted as saying the savings were needed to close a budget deficit for the state and the human services budget achieved real savings with minimal impact on service, access and outcomes.

CMS Delays Cost Sharing Flexibility in Medicaid Rule
As you may recall, states had been given the flexibility to increase cost sharing and premiums through the 2005 Deficit Reduction Act. Last November, the Bush administration issued the rules that were touted to not only save billions in state and federal expenditures but interject the concept of personal financial responsiblity among enrollees.

"A child of five would understand this. Send someone to fetch a child of five."
--Groucho Marx

Upon arrival in the White House in January, the Obama administration immediately delayed implementation until March 27th and has extended that delay until December 31, 2009. They said it would not be in the public's interest to move forward with the cost sharing provision when it does not conform to statutory requirements under the ARRA (the recently enacted stimulus package for Medicaid). Any additional public comments on the regulation are now due to CMS April 27, 2009.

Questions From the Frontlines
How many states allow dental hygienists to perform a dental diagnosis? None. An examination of all dental practice laws and administrative code regulations reveals that a defining element of practicing dentistry includes diagnosing or holding oneself out as being able to diagnose diseases and conditions of the oral cavity. Laws and regulations in many states take the additional step of prohibiting dental hygienists from diagnosing or authorizing dentists to delegate diagnosing to dental hygienists.

ADA policy includes diagnosis within those functions or procedures that require the knowledge and skill of a dentist and therefore must be performed only by a licensed dentist.

As it stands, fifty states and the District of Columbia say diagnosing diseases and conditions of the oral cavity is the practice of dentistry. Twenty states take the additional step of prohibiting dental hygienists from diagnosing. Nineteen prohibit the delegation of diagnosis to dental hygienists. To date, one state allows for diagnoses and treatment plans for hygiene service by dental hygienists. These are limited to "dental hygiene" diagnosis and do not apply to complete dental diagnosis and treatment plan.

"Is this art or is this madness?"
Berliner Borsen-Courier

Mobile Dental law in Arkansas
The Arkansas Dental Association was successful in getting its mobile dental unit bill enacted into law in early 2009. The intent of the law is to get care to those who need it and protect those patients. The measure ensures that the patient is not merely abandoned after treatment is delivered and procedures are in place in the event the patient needs emergency follow-up care.

The law allows for the Arkansas State Board of Dental Examiners to grant permits for the operation of a mobile dental facility upon obtaining proof that all requirements are fulfilled. A key requirement is that operators of mobile dental units determine if patients have an established "dental home" - a primary dental care provider in the area who has an ongoing relationship with the patient. The operator must contact that dental home to determine if there is already a scheduled appointment and if so to encourage the patient or the patient's parent or guardian to obtain care at their dental home. The unit must be self contained and inspected by the board.

In 2008 the state of **Mississippi** adopted comprehensive regulations governing the operation of mobile dental facilities or portable dental operations.

The operator of a mobile dental facility must be a Mississippi licensed dentist and possess a current mobile dental office registration issued by the dental board.

The board must be provided a list of names of dentists to whom the operator of the mobile dental facility will refer patients for follow-up care, subject to the patient's right to choose another dental care provider. A mobile dental facility or portable dental operation that accepts a patient and provides preventive treatment, including prophylaxis, radiographs, and fluoride, but does not follow-up with treatment when such treatment is clearly indicated, is considered to be abandoning the patient. Arrangements must be made for treatment services by either the operator or other licensee who agrees to provide follow-up care.

No services may be performed on minors without a signed consent form from the parent or guardian, which indicates: (1) if the minor already has a dentist, the parent or guardian should continue to arrange dental care through that provider; and (2) the treatment of the child by the mobile dental facility or portable dental operation may affect the future benefits that the child may receive under private insurance, Medicaid or the state Children's Health Insurance Program (SCHIP).

"If you want to be happy, be."
--Leo Tolstoy

The mobile dental facility or portable dental operation shall be inspected by a board member or a staff evaluator prior to receiving approval to operate and shall be subject to periodic, unannounced audits by any board member or a staff evaluator.

Mercury Containing Products – The Danish Way

Denmark, following Sweden and Norway, became the latest Scandinavian country to take action on products containing mercury. Effective this summer (pending final EU approval), products containing mercury will no longer be sold in Denmark.

The action was taken for environmental reasons. Significantly, the Danish government recognized that dental amalgam needs to remain available, at least in certain circumstances. The Danish law explicitly exempts dental amalgam from the prohibition (for use in permanent molar teeth) where an amalgam filling will last longer than a plastic filling and where there is:

a) no opportunity to keep the tooth dry,
b) difficult cavity accessibility,
c) particularly large cavities, or
d) a large distance to neighbouring teeth.

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