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President Obama’s fiscal year (FY) 2014 budget for the U.S. Department of Health and Human Services (HHS) would save an estimated $361.1 billion over 10 years. The HHS budget totals $967.3 billion in outlays and proposes $80.1 billion in discretionary budget authority. Some of the budget requests that affect programs of interest to dental education on the state level are highlighted below:

The Centers for Medicare & Medicaid Services (CMS):

- **Federal Health Insurance Marketplaces (Exchanges)**

CMS’ program-level request for the marketplaces totals $2 billion in FY 2014, to support the first year of program operations. This program level consists of a request for $1.5 billion in discretionary program management resources and $450 million in anticipated user-fee collections. This funding will be used to implement several key activities, including: eligibility, enrollment, and appeals services; outreach and education; plan oversight; Small Business Health Option Program (SHOP) and employer support; information technology (IT) systems; and financial management. Twenty-six states have indicated that they will not operate a state-based marketplace or a state-federal partnership, and as a result, HHS will operate a federal marketplace (also called a federally facilitated exchange) in those states.

- **Health Care Fraud and Abuse Control (HCFAC)**

CMS requests $640 million in additional health care fraud and abuse control (HCFAC) funding in FY 2014, $311 million in ongoing discretionary funding and $329 million in proposed mandatory funding. The additional funding will allow CMS and its law enforcement partners to continue investing in activities that will reduce fraud in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).

- **Grants to States for Medicaid**

The FY 2014 Medicaid request totals $284.2 billion, an increase of $13.5 billion above the FY 2012 level. The majority of this increase is attributed to the Affordable Care Act (ACA) Medicaid expansion in FY 2014. This appropriation consists of $177.9 billion for FY 2014 and $106.3 billion in an anticipated advance appropriation from FY 2013. However, CMS notes that the FY 2014 Medicaid target is to increase the national rates of preventive dental service to 50%, 6 percentage points over the FY 2011 baseline.

- **Children’s Health Insurance Program (CHIP)**

The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) authorized funding for states, commonwealths, and territories in the amount of $17.4 billion in FY 2013. Under this appropriation, funding to states will increase $44 billion above the baseline over five years. In addition to CHIPRA, the ACA extends federal funding for the Children’s Health Insurance Program (CHIP) through FY 2015, appropriating $19.1 billion in FY 2014 and $21 billion in FY 2015. The FY 2014 target is to increase CHIP and Medicaid enrollment to more than 46.6 million children (Medicaid: 38,083,596/CHIP: 8,533,789), nearly 25% more children than were covered in FY 2008. The FY 2014 combined target is based on CMS’ assumption that approximately 3.1 million more children will be enrolled than in FY 2011. The increase is expected due to a combination of population increases, loss of employer-sponsored insurance, and extensive outreach to enroll children who are eligible, but unenrolled in light of the ACA coverage expansions.
Health Resources and Services Administration (HRSA):

- The National Health Service Corps (NHSC) **FY 2014 budget** requests an additional $10 million. The NHSC is funded from the Affordable Care Act in FY 2014. Funding will support scholarships and loan repayment awards, including 285 new State Loan Repayment Program awards. The State Loan Repayment Program (SLRP) is a grant program that offers a dollar-for-dollar match between the state and the NHSC for loan repayment contracts to health providers, including dentists and dental hygienists, who practice in a health professional shortage area (HPSA) in that state.

**Update on State Medicaid Expansion under the Affordable Care Act**

Twenty states and the District of Columbia plan to expand their Medicaid program under the Affordable Care Act (ACA), according to a recent report by Avalere. Under the ACA, as of January 1, 2014, Medicaid eligibility will be expanded to reach all children and adults under age 65 with incomes at or below 133% of the federal poverty level. On June 28, 2012, the U.S. Supreme Court upheld the ACA; however, the Court’s ruling allows the ACA’s Medicaid expansion to proceed, but without a provision threatening non-compliant states with the loss of their existing Medicaid funding. As a result, states can either opt-in or opt-out of the Medicaid expansion provision.

According to information released by the U.S. Department of Health and Human Services, there will be no deadline for states to decide whether to participate in the Medicaid expansion; however, the longer states take to opt-in, the less that state will receive in federal matching funds. Specifically, the ACA provides 100% federal matching funding for covering newly eligible Medicaid recipients in states that choose to expand for 2014, 2015, and 2016. For later years, the federal match decreases until it reaches 90% for 2020 and subsequent years.

To learn which states plan to expand their Medicaid program under the ACA and which states plan to opt-out, click on the [U.S. map](#). Please be aware that some states are still considering legislation related to Medicaid expansion and, as a result, the map may change. On May 2, West Virginia Governor Earl Ray Tomblin (D-WV) **announced** that the state would expand Medicaid and cover more than 91,000 additional West Virginians. Additionally, on May 9 Governor Steve Beshear (D-KY) **announced** that the state would expand Medicaid to cover 308,000 more individuals. The governor stated that the expansion of Medicaid in Kentucky would create nearly 17,000 new jobs and have a $15.6 billion positive economic impact on the state between its beginning in fiscal year 2014 and full implementation in fiscal year 2021. To learn more about the governor’s decision to expand Medicaid click [here](#). According to staff from both governor’s offices, no enabling legislation is required to expand Medicaid in their states.

**U.S. Department of Health and Human Services Releases Letter to Issuers on Federally-facilitated and State Partnership Exchanges**

On April 5, the U.S. Department of Health and Human Services (HHS) released a [letter](#) to issuers on federally-facilitated and state partnership exchanges. The letter primarily provides issuers seeking to offer Qualified Health Plans (QHPs) in federally-facilitated and state partnership exchanges with operational guidance. Specifically, the letter provides operational guidance related to stand-alone dental plans. According to the letter issued by HHS, the following applies to stand-alone dental plans seeking certification as a QHP:

- **Prohibition on Annual and Lifetime Dollar Limits**

  The pediatric dental essential health benefit (EHB) offered by stand-alone dental plans certified to be offered in the exchanges must be offered without annual and lifetime limits.
• Annual Limits on Cost-Sharing

Stand-alone dental plans certified to be offered inside an exchange will be required to demonstrate to the exchange that they have a reasonable annual limitation on cost-sharing in place. The exchange is responsible for determining "reasonableness." There are separate specific dollar limits that apply to cost-sharing for comprehensive medical QHPs.

For the 2014 coverage year in the federally-facilitated exchange (FFE), the Centers for Medicare & Medicaid Services (CMS) interprets "reasonable" as it relates to stand-alone dental plans to mean any annual limit on cost-sharing that is at or below $700 for a plan with one child enrollee, or $1,400 for a plan with two or more child enrollees.

• Certification of Stand-Alone Dental Plans

Stand-alone dental plans must meet applicable certification standards related to EHBs, maximum out-of-pocket limits, network adequacy, and marketing.

• Displaying Stand-alone Dental Plan Rates

The exchanges are required to collect and display premium rate information for all QHPs, including stand-alone dental plans, in a standardized and comparable way. CMS will also display comparable rate information as well as calculate the advance payment of the premium tax credit for stand-alone dental plans using the pediatric dental EHB premium allocation. Stand-alone dental plans must indicate to consumers whether they are guaranteeing the information displayed in the rate table or reserving the option to charge additional premium amounts.

• Separately Offering and Pricing Stand-Alone Dental Plans

Each exchange may require, as a condition of certification, comprehensive medical QHPs to offer and price the pediatric dental EHB (if covered) separately, if doing so would be in the best interest of consumers.

For the 2014 coverage year, CMS will not require comprehensive medical QHP issuers that provide pediatric dental coverage to offer and price the pediatric dental EHB separately from the rest of the plan in connection with certification by an FFE.

• Data Collected Through the Stand-Alone Dental Plan Voluntary Reporting Program

CMS created a voluntary reporting program to determine in which exchanges dental issuers were likely to offer stand-alone dental plans. The data indicate that a stand-alone dental plan is expected to be offered in each state in which a FFE and a state partnership exchange will be operating. As a result, QHP issuers participating in FFEs and state partnership exchanges can expect to have the option to omit the pediatric dental EHB because stand-alone dental plans will be offered in those exchanges.

Medicaid and CHIP Payment and Access Commission Discusses Adult Dental Services

On April 11, the Medicaid and Children’s Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) met to hear testimony related to adult services under Medicaid. MACPAC was established in the Children’s Health Insurance Program Reauthorization Act of 2009. MACPAC is generally tasked with reviewing state and federal Medicaid and CHIP access and payment policies, as
well as making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and states on various issues impacting Medicaid and CHIP populations. On April 11, MACPAC members heard invited testimony from the following: Terry Dickinson, D.D.S., Executive Director, Virginia Dental Association; Mina Chang, Ph.D., Chief, Health Research and Program Development, Ohio Office of Medical Assistance; and Paul Glassman, D.D.S., M.A., M.B.A., Professor of Dental Practice, Director of Community Oral Health, Arthur A. Dugoni School of Dentistry at the University of the Pacific.

Following the presentations, MACPAC members made comments related to the need for alternative workforce models, and the cost associated with recommending that Medicaid cover adult dental services. MACPAC is just beginning its discussion of Medicaid coverage for adult dental services. ADEA will keep members updated with any new information.

To view the materials presented to MACPAC by Dr. Dickinson, Dr. Chang, and Dr. Glassman, click here.

The Centers for Medicare & Medicaid Services Issues an Informational Bulletin on Oral Health Initiatives and Other Dental Issues

On April 18, the Center for Medicaid and Children’s Health Insurance Program (CHIP) Services (CMCS) within the Centers for Medicare & Medicaid Services (CMS), issued an informational bulletin setting baselines and goals for children enrolled in Medicaid and CHIP. Specifically, the bulletin states the following goals:

- Increase by ten percentage points, from FY 2011, the percentage of children ages 1-20 who have been enrolled in Medicaid for at least 90 continuous days and who have received a preventive dental service. The target date for this goal is FY 2015.
- Increase by ten percentage points the percentage of children ages 6-9 who have been enrolled in Medicaid for at least 90 continuous days and who have received a sealant on a permanent molar.

CMCS previously asked state Medicaid agencies to develop Oral Health Action Plans as a roadmap to achieving certain goals, such as increases in the number of children enrolled in Medicaid. The bulletin encourages states that have not submitted plans to do so.

Additionally, the bulletin provides information on two new codes for dental providers. The October 2012 version of the American Dental Association’s Current Dental Terminology (CDT) includes two new codes for diagnostic services that do not specify a dentist as the rendering provider. CMCS believes these services will support states in their efforts to maximize the ability of all healthcare professionals, operating within the scope of state practice acts, to serve Medicaid and CHIP enrollees. The two new codes are:

- D0190 – Screening of a patient. A screening, including state or federally mandated screenings, to determine an individual’s need to be seen by a dentist for a diagnosis.
- D0191 – Assessment of a patient. A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.

A state that chooses to cover and pay for these services through CHIP would not need to submit a State Plan Amendment (SPA) reflecting the change. Likewise, a state that already covers and pays for these services through Medicaid, but does not use the D0190 and D0191 billing codes, would not need to submit a SPA.
The Centers for Medicare & Medicaid Services Announces a New Technical Assistance Center for States on Medicaid Managed Care

The Centers for Medicare & Medicaid Services (CMS) announced a new technical assistance center for states related to Medicaid Managed Care. Specifically, direct technical support is available from CMS to assist state Medicaid agencies in developing, enhancing, implementing, and evaluating managed care programs. Technical support related to providing dental services under Medicaid is also available to state Medicaid agencies.

The District of Columbia Bans Health Insurers from Charging Higher Premiums for Smokers

The Affordable Care Act (ACA) permits states to allow health insurers to charge smokers buying individual policies up to 50% higher premiums. Additionally, the ACA requires all new private health insurance plans to cover services recommended by the U.S. Preventive Services Task Force (USPSTF) with no cost-sharing. These recommendations include tobacco cessation treatments. Individual states can adjust the size of the maximum surcharge within their borders in various ways, ensuring a lower financial barrier to coverage.

On April 8, the District of Columbia Health Benefit Exchange (HBX) Executive Board voted to prohibit health insurance companies from charging higher premiums to smokers and tobacco users. According to the District of Columbia HBX, an estimated one in five residents of the District of Columbia use tobacco regularly, with rates especially high among African-Americans, an estimated 30.8%.

California Takes a Look at Online Course Offerings

S.B. 520, sponsored by Senate President Pro Tempore Darrell Steinberg (D-CA), passed the Senate Committee on Education by a vote of 8-0, and has been referred to the Senate Committee on Appropriations for further consideration. This bill would establish the California Online Student Access Platform (platform) under the administration of the President of the University of California, the Chancellor of the California State University, and the Chancellor of the California Community Colleges. The bill would also require the platform, among other things, to provide an efficient statewide mechanism for online course providers to offer transferable courses for credit, and to create a pool of these online courses. Further, the bill would require that students taking online courses developed through the platform who achieve a passing score on course examinations be awarded full academic credit for an equivalent course at the University of California, the California State University, or the California Community Colleges.

A.B. 1306, sponsored by Assembly Member Scott Wilk (R-CA), was referred to committee and set for a hearing; however, the hearing on the bill was cancelled by the bill author. The bill would establish The New University of California as a 4th segment of public postsecondary education in the state. The bill would also establish an 11-member Board of Trustees of The New University of California as the governing body of the university. In addition, under the proposed legislation, the mission of The New University of California is to issue college credit and baccalaureate and associate degrees to any person capable of passing examinations administered by the university. According to the bill text, the goal of the university is for its students to obtain the requisite knowledge and skills to pass the examinations administered by the university from any source, such as massive open online courses (MOOCs), the student deems appropriate.

Texas Health and Human Services Commission Holds Dental Stakeholder Meeting

Over the last year the Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) has increased its focus on dental practitioners in Texas serving Medicaid and CHIP patients. The initial focus by the Texas HHSC OIG was related to improper solicitation of Medicaid clients by dentists; however, their focus seems to now include any Medicaid fraud, waste, and abuse.
As a result of the increased scrutiny on dentists, the Texas HHSC began holding Quarterly Medicaid Dental Provider Stakeholder Meetings. These meetings are open to all Medicaid dental providers, and allow Medicaid dental providers to provide feedback directly to staff from the Texas HHSC. On April 24, the Texas HHSC held a Quarterly Medicaid Dental Provider Stakeholder Meeting.

The Texas HHSC announced in September 2012 that the agency and Delta Dental agreed to end Delta Dental's contract to provide children's Medicaid and Children's Health Insurance Program (CHIP) dental services on November 30, 2012. Beginning December 1, 2012, members began receiving services through DentaQuest or MCNA Dental. Representatives from MCNA Dental and DentaQuest presented information during the stakeholder meeting. Both entities shared information regarding the creation of provider portals for appeals. Appeals can be submitted electronically through these provider portals. This change came as a result of concerns raised in previous stakeholder meetings regarding the time and complexity needed to file a claim or appeal. MCNA Dental will begin Lunch-and-Learns and a Dental Details Monthly Newsletter to assist dental providers in keeping up with changes in Medicaid. In addition, MCNA Dental and DentaQuest are providing dentists and dental clinics with new provider manuals.

New York Continues to Focus on Tobacco Regulations

At the request of Mayor Michael Bloomberg (I-NY), legislation has been introduced to further reduce smoking in New York City. According to Mayor Bloomberg, the bill, called The Tobacco Product Display Restriction Bill, prohibits the display of tobacco products to protect children from the marketing of cigarettes through their display at retail counters. Specifically, the bill would require that tobacco products be stored out of public view, except during a purchase by an adult consumer or restocking.

According to Dr. Thomas Farley, Commissioner of the New York City Department of Health and Mental Hygiene, “New York City’s comprehensive smoking prevention program has led to a decrease in the smoking rate in adults from 21.5% in 2002 to 14.8% in 2011. However, smoking remains the leading preventable cause of death in New Yorkers, killing thousands per year, and youth smoking rates have remained flat at 8.5% since 2007.”

In addition, seven members of the New York City Council have co-sponsored an amendment increasing the tobacco purchase age from 18 to 21 years of age, with the goal of reducing smoking and tobacco use by 18 to 20 year olds, and increasing the likelihood that people in this cohort will not become smokers later in life. The amendment was added to legislation previously introduced in 2010, which attempted to increase the purchase age to 19 years of age, but the bill failed to pass out of the Committee on Health.

On May 2, the New York City Council Committee on Health held a hearing on the bills and accepted testimony, however, no vote was taken.

With regard to state legislation, Senator Diane J. Savino (D, IP, WF-NY) has introduced S.B. 4863. The proposed bill increases the tobacco purchase age from 18 to 21 years of age in the state of New York. On May 1, Assemblywoman Linda Rosenthal (D-NY) introduced similar legislation in the New York State Assembly, A.B. 7105. The bill has five co-sponsors. Both bills have been referred to committee.

State Policy Updates

- **Mississippi**

H.B. 776 was signed into law by Governor Phil Bryant (R-MS) March 20. The new law establishes the Mississippi Rural Dentists Scholarship Program and a governing commission to promulgate rules and regulations for participation in the scholarship program. The program will consist of three phases through which participants will progress: (a) undergraduate pre-dental education; (b) dental
school and residency; and (c) initial entry into dental practice in a rural or underserved area of the State of Mississippi. The law becomes effective July 1.

- **Texas**

S.B. 143, sponsored by Senator Jane Nelson (R-TX), and co-sponsored by seven other senators, passed the full Senate by a vote of 31-0, and has been referred to the House Committee on Higher Education for consideration. The bill requires the Texas Higher Education Coordinating Board (THECB or board) to administer the Resident Physician Expansion Grant Program as a competitive grant program to encourage the creation of new graduate medical education positions through community collaboration and innovative funding. Specifically, the bill requires the board to award grants to physician residency programs at teaching hospitals and other appropriate health care entities. Under the bill, the board may provide grants only to support a residency position that: (1) is created and accredited on or after January 1, 2014; or (2) was created and accredited before January 1, 2013, but as of that date had not yet been filled. In addition, a grant award may be used only to pay direct costs associated with the position, including the salary of the resident physician. Also, the bill establishes a grant program under which the board awards incentive payments to medical schools that demonstrate an increase in the number of physicians who practice in primary care in the state following their residency training.

**Reports of Interest**

The Association of State and Territorial Dental Directors and the Medicaid – Children’s Health Insurance Program (CHIP) State Dental Association developed a tip sheet that provides examples of successful State Oral Health Program and State Medicaid-CHIP Oral Health Program collaboration. Program collaboration in Alaska, Iowa, Maryland, Massachusetts, and Michigan were highlighted in the tip sheet.

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a report providing highlights of Medicaid-related investigations conducted in fiscal year 2012. The report details investigation activities related to the following topics: Medicaid-related beneficiary safety and quality of care; wasteful spending; improper state claims for federal reimbursement; and fraud and abuse. Additionally, the report makes note of ongoing investigations of billing practices and patterns related to providing dental services for children enrolled in Medicaid (see PDF page 46).

Health Affairs and the Robert Wood Johnson Foundation released a health policy brief exploring the implementation of per capita caps in Medicaid. The proposed health reform policy would impose a cap on the amount of federal spending per Medicaid beneficiary, called a “per capita cap,” so that any program spending growth would be linked to enrollment, not rising per beneficiary spending. According to the policy brief, Medicaid cost $432 billion in 2011, and Medicaid spending is expected to grow to $795 billion by 2021.

The Center on Budget and Policy Priorities issued a report finding that most state revenue in fiscal year 2011 went to education and health care. Specifically, states spent 15% on Medicaid and the Children’s Health Insurance Program (CHIP), approximately $150 billion. In addition, states spent an average of 14% on higher education, or about $140 billion.

The National Academy for State Health Policy and the Robert Wood Johnson Foundation released an issue brief which highlights the Affordable Care Act (ACA) Medicaid requirements that will take effect in the next two years, nearly all of which apply to every state regardless of whether the state chooses to expand Medicaid eligibility.
Trust for America’s Health has released a series of state-specific one-pagers on the Prevention and Public Health Fund (Fund), which was created in 2010. One-page documents have been created detailing the fund’s impact on specific states.

ADEA/Sunstar Americas, Inc./Jack Bresch Student Legislative Internship

The ADEA/Sunstar Americas, Inc./Jack Bresch Student Legislative Internship is a six-week, stipend-supported internship in the Advocacy and Governmental Relations portfolio of the ADEA Policy Center (ADEA AGR) in Washington, D.C. This student legislative internship provides a unique learning experience for predoctoral, allied, and advanced dental student residents, and fellows. It is designed to encourage students to learn about and eventually—as dental professionals—to become involved in, the federal legislative process and the formulation of public policy as it relates to academic dentistry. It is open to any predoctoral, allied, or advanced dental student resident, or fellow who is interested in learning about and contributing to the formulation of federal public policy with regard to dental education, dental research, and the oral health of the nation. Funded through the generous support of Sunstar Americas, Inc., the student intern will be a member of the ADEA AGR staff and will participate in congressional meetings on Capitol Hill, coalition meetings, and policy discussions among the ADEA Legislative Advisory Committee (ADEA LAC) and ADEA AGR staff.

An applicant must be a full-time predoctoral, allied, or advanced dental student resident, or fellow whose institution is willing to work with the student to identify an appropriate time, consisting of six weeks, during the school year to pursue the internship. For additional information, please email Yvonne Knight, J.D., ADEA Senior Vice President for Advocacy and Governmental Relations, at KnightY@ADEA.org. Applications are accepted on a year-round basis.

The ADEA Policy Center publishes the ADEA State Update monthly. Its purpose is to keep ADEA members abreast of state issues and events of interest to the academic dental and research communities.

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