

Vermont State



Dental Society

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A CONSTITUENT OF THE AMERICAN DENTAL ASSOCIATION

Comments on the FY'2010 Governor's Proposed Budget - Reductions in the adult Medicaid dental program to House Appropriations Committee.

Peter Taylor, Executive Director
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The Vermont State Dental Society appreciates that the current proposals do not diminish the Vermont Children's Medicaid Dental program.

The Vermont State Dental Society is, however, very concerned and urges a careful evaluation of the proposal to reduce the current annual cap on adult dental services covered by the Vermont Medicaid program. The proposal recommends reducing the current yearly maximum from \$495 to \$200.

We have presented testimony to the House Committee on Health Care and it reflects the dental society's position of last year. We would be pleased to appear before the Appropriations Committee if you would like.

Vermont is a leader in the nation in access to dental care for Medicaid recipients, with most independent dentist's treating Medicaid patients. You may not realize that over 80% of Vermont Medicaid dental services are provided by private dental practices.

We might quickly comment that there are three different reimbursement methods for providers of Medicaid dental services: the traditional Fee schedule; Supplemental payments for a few practices, and - cost based reimbursement for FQHCs. Because of this, changes to the program may impact individual practices differently. We can provide more detail on payments if you would like.

Dental disease itself is not the only reason to advocate for the availability of access to oral health services.

Committee members may have already heard comments on the possible relationship of oral health with pregnancy preterm delivery and the clarification in research for the possible linkages between chronic disease and oral disease. It has been documented that diabetes and smoking are the two most important risk factors for periodontitis. People with diabetes are twice as likely to develop periodontal disease. The question now is does it apply the other way and will it be proven that the lack of good oral health in the Medicaid population contributes to chronic diseases in these populations?

The science of the relationship of oral health to medical conditions warrants careful consideration as it continues to develop.

Next, there are some specific comments about the Adult Medicaid Dental Program. Currently the scope of benefits for the adult Medicaid dental program includes dental examinations, palliative treatment, prevention, and limited dental restorative procedures and extractions. Except in emergency situations (pain and infection) these procedures are limited on a yearly basis by a \$495 expenditure cap. (Note: this is the same as it was in 1992.)

The program would become even more restrictive if the yearly maximum expenditure is reduced even further. (Note: few procedures, palliative in nature, are excluded from the yearly cap when provided in emergent situations)

If a \$200 maximum is implemented, very few services can be provided over the course of a year for a population that is likely to be in need of more extensive services. The Medicaid fees are in the 40-70% range of normal charges.

Once an adult Medicaid recipient reaches the yearly maximum, they are eligible for the state General Assistance program with very limited emergency dental benefits; primarily extractions. Once determined eligible for General Assistance, vouchers are issued...as a means of providing emergency treatment to relieve pain, bleeding and/or infection..."

In conclusion, we are strongly opposed to the reduction in the yearly maximum.