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State Legislative Report

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What's Inside

Sound Byte

The Medicaid fee increase, program improvements, and the recession resulted in a dramatic increase in utilization rates. For children continuously enrolled in Medicaid, utilization rates increased from 45.9% in 2006 to 71.6% in 2012.

Source: PubMed Overview of *JADA* article (Click here) "Impact of fee increases on dental utilization rates for children living in Connecticut and enrolled in Medicaid." (2015 Jan;146(1):52-60)

"I can accept failure, everyone fails at something. But I can't accept not trying."

– Michael Jordan

EPA Postpones Amalgam Separator Rule Again

The Environmental Protection Agency (EPA) announced recently that it would delay releasing a final amalgam separator rule until summer 2016. The agency had been prepared to release the rule any time, but announced the postponement after determining it needed more time to review all comments it received.

Speaking to wastewater utility officials at the National Pretreatment and Pollution Prevention Workshop in Greenville, South Carolina, Jan Matuszko, chief of the EPA Office of Water's Engineering and Analytical Support Branch, explained that part of the reason for the delay is that the

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agency needs more time to address the regulatory burden the rule would create.

The ADA is encouraged by the EPA's willingness to work with the profession as it develops its rule. In February the Association commented on a draft of the rule by noting that the ADA's support "is contingent only on the final rule complying with nine common-sense principles" and reaffirming its "support of a pretreatment rule that requires amalgam separators consistent with these nine principles."

The ADA comments included specific suggestions on how to improve the proposed rule and eliminate several areas of ambiguity and internal inconsistencies. The Association remains hopeful that EPA will incorporate its suggestions in a final rule which the Association can support. The ADA has long supported amalgam separators, and their use is widespread.

Medicaid Legislative Update

Medicaid Audit

At least eight states have filed bills this year to regulate how Medicaid provider audits will function. Concerns have been raised by members about the impact audits may have on access to Medicaid services for enrollees. In response, some states have filed bills establishing a higher degree of due process in the Medicaid audit programs. Some of the recurring criteria of Medicaid audit bills appears to be, generally:

1) limits on extrapolations;

2) limits on file requests;

3) provider appeals opportunities;

4) inclusion of properly licensed/experienced provider in reviews;

5) fair payment methodology for auditor (contingency v. flat fee);

6) reasonable scheduling of provider audits;

7) audits based on provider history;

8) exempting clerical errors from offense; and

9) supplying provider training.

Of the eight states filing bills this year, three have been enacted – Connecticut, Nebraska and Utah. Missouri enacted a law that also helps ensure transparency.

Nebraska's new law provides several new requirements for Recovery Audit Contractors (RACs). For example, the new law declares that all RACs may only review claims within two years from the date of the payment. With some exceptions, it limits the number of records that can be requested and requires audit be concluded within sixty days. The law creates a method where improper payments identified may be resubmitted as a claims adjustment.

RACs must utilize licensed health care professionals that practice in the area being audited to help ensure greater legitimacy of audits. The new law also creates requirements for communicating pertinent information to providers being audited and establishes a formal and informal appeals process. Unless there is just cause, overpayments are

"If your actions inspire others to dream more, learn more, do more and become more, you are a leader."

– John Quincy Adams

not collected until all appeals have been completed, and audits must be scheduled in advance. The law limits the file requests, as well, and requires training for providers. Metrics on auditor(s') performance must be published annually.

The new audit law in Utah requires audits/reviews to include medical or dental professionals experienced in the treatment, billing, and coding procedures used by the type of provider being audited. Extrapolation is limited to providers exceeding an established payment error rate over time and those exceeding $200,000 in Medicaid claims for a particular service code annually. Documented education intervention must have failed to correct the level of payment error. If the state (or contracted auditor) intends to use extrapolation as a method of auditing claims, it must first be reported to the legislature. Any entity with which the office contracts, for the purpose of conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.

Notification and statistically sound audit methodology are the hallmarks of the Connecticut law passed this year. The state enacted a comprehensive Medicaid audit law last year. This new law supplements the 2014 enactment. Contact information for the auditor is now required. The law alters the screens for using extrapolation and amends the appeal process.

Missouri passed a law related to Medicaid audit due process. To ensure providers are aware of changes in state Medicaid compliance matters, the state must notify providers of any changes to interpretation or application of reimbursement requirements.

The Medicaid audit bills in Kansas, Maryland, Montana, New Mexico and Washington included a variety of the "recurring criteria" enumerated above. Though these did not pass, for some states, the legislation was fruitful in launching a discussion on Medicaid audit impacts in their state.

Medicaid Financing

Colorado established a Medicaid rate review process under a new law. The state must review rates to assess if payments are sufficient for provider retention and client access. Revisions to the adult dental Medicaid services rule in Colorado were permanently adopted becoming effective on April 30, 2015. Active feedback from stakeholders prompted the state to remove unnecessary prior authorization requests, helping ensure a more positive Medicaid provider experience.

According to a state published newsletter, the "across-the-board" dental fee increase and targeted rate increases approved by the Colorado legislature are in process, at this writing. The targeted rate increases include fees for dental intra-oral complete mouth series radiographs (i.e., full mouth series x-rays), dental sealants for children, certain amalgam

"Life is really simple, but we insist on making it complicated."

– Confucius

and resin-based composite fillings, as well as various extraction and surgical extraction procedures.

A new Minnesota law increases payment rates for services furnished by rural dentists (located outside of the seven-county Minneapolis/St. Paul metropolitan area) by the "maximum percentage possible above the rates in effect on June 30, 2015." New in Missouri is a law that forgives assessments, penalties, interest (et. al.) on unpaid state taxes from September 1, 2015, to November 30, 2015. To qualify, the taxpayer must pay the tax due. The revenue generated by this amnesty is earmarked to supplement costs for the increased number of Medicaid enrolled adults (as approved by the state) receiving dental coverage and an increase in the reimbursement to Medicaid providers.

The Arizona (See Sec. 16 and 17) legislature authorized state Medicaid to reduce rates for providers up to five percent for the 2016 fiscal year. The law did allow that reduced utilization could mitigate the reductions. After reviewing public comment from a wide variety of stakeholders, including the dental profession, the state determined that no provider rate reductions were necessary to meet the reductions called for in the new law. The state credited stakeholders' comments for helping to guide the decision to NOT reduce reimbursement at this time. Additionally, under a new law affecting teledentistry in Arizona, the state Medicaid administration must implement/cover teledentistry services for enrolled members under twenty-one years of age.

Dental Medicaid rates in Illinois were reduced almost 17 percent from May to July this year under a new law. Under implementation of the law, a few procedure codes were exempted from the reduction such as exams, prophys, fluoride varnishes and sealants.

Dental Benefit Program State Legislative Update

Enacted into Law

Coordination of Benefits

A new law in South Dakota adds group and non-group insurance contracts and subscriber contracts that pay for the cost of dental care to the list of plan types that are impacted by the state's Coordination of Benefits (CoB) law. The existing CoB requirement says that if the secondary plan wishes to coordinate, it must calculate the benefits without regard to other health care coverage and apply that to the unpaid balance under the primary plan. The secondary plan may reduce its payment so total benefits paid do not exceed one hundred percent of the total allowable expense for that claim.

A new law in Nevada addresses payment arrangements where a claim is submitted for oral and maxillofacial surgeon services that may be covered, in whole or in part, by a stand-alone dental benefit plan and a policy of health insurance. In such cases, the stand-alone dental benefit

"You have enemies? Good. That means you've stood up for something, sometime in your life."

– Winston Churchill

is determined to be the primary policy and the claim must be first submitted to the health insurer that issued the stand-alone dental benefit. The issuer of the secondary policy may not reduce benefits based upon payments under the primary policy, except to avoid overpayment to the oral and maxillofacial surgeon.

The new law generally prohibits a health insurer from denying a claim for which it has liability solely on the basis that another health insurer is required to pay the claim.

A Texas law enacted this year would require that when two dental plans cover an individual, the primary insurer is responsible for dental expenses to the full amount of the applicable policy limit. Before the primary insurer limit is reached, however, the secondary insurer must cover dental expenses covered by the secondary insurer that are not covered by the primary insurer. After the policy limit under the primary plan has been reached, the secondary insurer is responsible for any dental expenses covered by both policies that exceed the policy limit under the primary plan, up to the full amount allowed under the secondary insurer.

Non-Covered Services
There are now **36** states with non-covered service laws; Alabama enacted their law in June. Alabama now prohibits insurers from requiring a dentist to provide services at a fee set by the policy or plan unless the services are covered by the policy or plan. A few states filed bills this year setting similar prohibitions for benefit plans covering optometric services.

Insurer Rating of Dentist
Colorado added dentists to the state law that sets minimum standards on methods used to collect, analyze and publish any kind of rating designation (i.e. star, tier, rating, profile). The law also requires health care entities to provide dentists the right to challenge and correct erroneous designations, data, and methodologies used for rating the dentist.

Retroactive Denial
A new law in Hawaii limits insurers to a certain amount of time to initiate recoupment or offset efforts. Barring some exclusions, an entity would have up to eighteen months to initiate recoupment or offset efforts starting on the date the initial claim payment was received by the health care provider.

Required Coverage
A new law in Hawaii requires insurers to provide coverage for medically necessary orthodontic services for the treatment of orofacial anomalies.

Telemedicine
A new law in Nebraska says an insurer must provide, upon request to a policyholder, certificate holder, or health care provider, a description of the telehealth and telemonitoring services covered under the relevant policy, certificate, contract, or plan.

All Payer Claim Database
Arkansas established the *Healthcare Transparency Initiative* under the

"It is the mark of an educated mind to be able to entertain a thought without accepting it."

– Aristotle

law recently enacted. It would create a database that receives and stores data relating to medical, dental, pharmaceutical and other insurance claims information.

Medical Loss Ratio
Washington's new law requires health carriers offering a dental only plan to report the dental loss ratio that is computed by dividing the total amount of dental payments by the total amount of dental revenues. The plans must also report the percentage change in the average premium per member per month, as measured from the previous year. The information must be made available to the public in a format that allows comparison among carriers through a searchable public website. Finally, the law clarifies that this is not intended to establish a minimum dental loss ratio.

The new law also prohibits a health carrier offering a dental only plan from denying coverage for treatment of emergency dental conditions, as defined in the bill, that would otherwise be considered a covered service of an existing benefit contract. Said denial would have been due to the fact that the services were provided on the same day the covered person was examined and diagnosed for the emergency dental condition.

Credentialing
An enactment in Louisiana allows that a dentist credentialed by a health insurance issuer for any location in the state is considered credentialed for all locations where the provider may legally practice dentistry. The dentist must give notice of any additional locations of practice beyond the primary practice and any additional practice location(s) originally noted on the provider's initial credentialing application form. Not less than thirty days prior to the time at which the provider begins practicing at any additional location, another provider who is current on all credentialing with that health insurance issuer must have been practicing there.

Bills Pending

Non-Covered Services
Including Alabama with their enacted NCS law, six states have filed non-covered services bills this year. At this writing, the Ohio and Massachusetts (HB 951 and SB 566) are the only active states with such a bill.

Assignment of Benefits
North Carolina has a bill that would allow the insured to direct payment to the dentist. The bill specifies that this includes limited-scope dental plans. The terms of an assignment arrangement would have to be renewed annually.

Retroactive Denials
An insurer in Pennsylvania would be limited to twelve months after the date that the insurer pays a claim to retroactively deny reimbursement to a health care provider, so long as no issue with fraudulent behavior or improper coding is identified. The bill also would require insurers that

"Research is formalized curiosity. It is poking and prying with a purpose."

– Zora Neale Hurston

retroactively deny to provide the health care provider a written statement specifying the basis for the denial.

Silent PPOS-Network Rental/Access
A New Jersey (A1050) bill would enact the Health Care Provider Network Transparency Act. It would establish requirements for plans that desire to grant access to provider discounts under a provider network contract. The intent is to prevent the improper selling or leasing of these contractual discounts.

All Payer Claims Database
California's bill would create an All Payers Claims Database. The bill would require certain health care entities, including health care service plans, to provide specified information to the database, which would then process, maintain, and analyze information from specified data sources, including, among others, disease and chronic condition registries. The bill would require the database to establish and regularly update a web-based, searchable catalogue. It also would require the establishment of a review committee composed of a broad spectrum of health care stakeholders and experts to, among other things, develop the parameters for establishing, implementing, and administering the database.

New Jersey (A952 and S1216) legislation filed in 2014 would establish the New Jersey All-Payer Claims Database within the Department of Banking and Insurance.

Medical Loss Ratio
A New York bill would require *Medicaid* Managed Care Organizations to spend not less than 85% on dental services.

Coverage for Services Provided via TeleMedicine/TeleDentistry
Bills in New Jersey (A3675 and S2338) received a "Do-Not-Pass" recommendation in their committees. The bills would have required health insurance carriers, the State Health Benefits Program, and the School Employees' Health Benefits Program to provide coverage for services provided via telemedicine in the same manner as would occur if provided through in-person consultation.

Joint Negotiations by Dentists and Physicians
A bill in New York would authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the state action exemption to the federal antitrust laws through the articulated state policy and active supervision provided under this article.

Did Not Pass/Failed

A comprehensive Georgia bill would have enacted four different aspects of dental benefit policy:

1) Insurer Transparency Act;

2) Providers' Right to Choose Act;

3) Provider Stability Act; and

4) Consumer Right to Access Act.

"Victorious warriors win first and then go to war, while defeated warriors go to war first and then seek to win."

– Sun Tzu

"Insurer Transparency Act" would enact a number of regulations on rental preferred provider networks, defined as a preferred provider network that contracts with health insurers or other payers or with another preferred provider network to grant access to the terms and conditions of its contract with medical physicians. The bill would require registration and means for revoking registration.

"Providers' Right to Choose Act" would prohibit health insurers from requiring a health care provider to participate in all health plans offered the health insurer, or to participate in all the insurer's provider network arrangements. It prohibits the health insurer from terminating any contractual relationship with a health care provider for not agreeing to participate in a provider network arrangement.

"Provider Stability Act" would require express agreement from the health care provider and insurer to execute a unilateral material change to a contract with a health care provider.

"Consumer Right to Access Act" would require each health insurer to maintain a sufficient network in numbers and types of providers to ensure reasonable accessibility. Emergency services must be accessible 24 hours per day, seven days per week. Prohibits health insurers from excluding from its provider network any appropriately licensed type of health care provider as a class.

The bill states that provider networks would have to be adequate to meet the comprehensive needs of the enrollees of the health insurer and provide an appropriate choice of health care providers sufficient to provide the services covered under the policies or plans of such health insurer.

Publication of Provider Fees

Colorado would have required a health care provider to make available to the public the health care price for at least the fifteen most common health care services, if applicable, the health care provider provides. The provider would have to provide a disclosure specifying that the price for any given health care service is an estimate, and that the actual charges for the health care service are dependent on the circumstances at the time the service is rendered.

Kansas would have required a carrier to establish a toll-free telephone number and website that enables an insured to request and obtain from the carrier information on the average price paid to a participating provider for a proposed admission, procedure or service in each provider network area established by the carrier and to request an estimate.

Insurer Rating of Dentist

Alabama's bills (HB 404 and SB 295) would have prohibited a health insurance entity from establishing a quality rating system for dentists using cost of services. A quality rating system would have been based only on data that is verified for accuracy, made transparent, fair, and accessible

"Be sure you put your feet in the right place, then stand firm."

– Abraham Lincoln

to dentists and consumers, and disclosed to the public.

Medical Loss Ratio
A Rhode Island (HB 5700) bill would have required dental plans in that state to submit a report on the percentage of revenue from premiums that is spent on dental care. The bill includes the intent that the reports are to be used in an effort to enact a law that adopts the MLR in 2019.

Teledentistry
Rhode Island's SB 321 (SUB A) would have required each health insurer to provide coverage for the cost of health care services provided via telemedicine.

Assignment of Benefits
Under a bill filed in Kansas this year, health insurers would have had to allow the insured to assign the reimbursement for covered care to the dentist who provides the dental care service.

Network Requirements
Kansas would have required the benefit amount paid for receiving dental services to be the same whether or not the insured's dentist is a participating provider and belongs to such health insurer's provider network. The bill also included an "any willing provider" clause. Any dentist licensed in the state with professional liability insurance would be eligible to join plans' networks.

Rhode Island (SB 382) would have required health carriers to maintain their network so it is sufficient in numbers and types of providers to assure all services would be accessible without unreasonable delay. With respect to emergency services, covered persons must have access twenty-four hours per day, seven days per week. A health carrier providing a tiered network plan would be required to ensure that all covered services be accessible through a provider in the lowest cost-sharing tier. The bill has been held for study.

A bill in Rhode Island (SB 491) would have required health insurers to maintain accurate and up-to-date directories of all in-network providers, and to provide that information to plan enrollees. The bill has been held for study.

A Rhode Island bill (HB 5176) would have required that health insurance policies include coverage for temporomandibular joint disorder.

Community Water Fluoridation

Eleven states filed bills that directly affect water fluoridation this year; taken together, there were thirteen bills filed. Nine of them were efforts to eliminate or hinder the practice. Three were poised to support it, and one was rather neutral. The big news, the bulk of the bills were efforts to thwart fluoridation and all died this session.

Enacted into Law

A new New York law now requires notice and justification be sent to the public before local governments may discontinue fluoridation. The notice also must include the availability of

"The world breaks everyone, and afterward, some are strong at the broken places."

– Ernest Hemingway

alternatives to fluoridation, and a summary of consultations with the department of health and health professionals concerning the proposed discontinuance.

If the local government wishes to proceed with the proposed discontinuance after receiving public comment, written notice to the state is required 90 days prior. The local unit must submit a plan that includes the final determination, the date of discontinuance, and alternatives to fluoridation, if any, that will be made available in the community.

The new law authorizes the state to make grants available to qualifying local governments to defray the cost of planning, design, construction, installing, repairing, replacing or upgrading water fluoridation equipment.

"Today you are you! That is truer than true! There is no one alive who is you-er than you!"

– Dr. Seuss