



**The Independent Office of the
Ombudsperson
For Mental Retardation**

Annual Report 2005



Table of Contents

- I. Introduction**
 - Ia. Mission Statement**
- II. Year 2005 Concerns**
- III. Areas of Concern**
- IV. Statistical Report of Concerns by Month**
- V. Percentage Increase of Concerns per Year**
- VI. HIPAA Related Activity**
- VII. Year in Review for Department of Mental Retardation**
- VIII. 2005 Accomplishments, Office of the Ombudsman**
- IX. President's Committee for People With Intellectual Disabilities**
- X. Office of the Ombudsman Objectives for 2006**
- XI. Appendix A**
- XII. Appendix B**
- XIII. Appendix C**

I. Introduction:

The Independent Office of the Ombudsperson for Mental Retardation (the Office of the Ombudsperson) was established on June 29, 2001, in accordance with Public Act No. 99-271, (Sec. 17a-210a). As mandated by statute, the Office of the Ombudsperson is submitting its annual report for January 1, 2005 through December 31, 2005.

I a. The Office of the Ombudsperson’s Mission Statement:

The Independent Office of the Ombudsperson for Mental Retardation works on behalf of consumers and their families. The office addresses complaints or problems regarding access to services or equity in treatment. Contact the office for information regarding rights and methods of dispute resolution concerning consumers and/or their families. The results and nature of complaints and concerns are communicated to the Mental Retardation Council, the State Legislature and the DMR Commissioner in order to better direct the resources of the department and to improve service to our consumers and/or their families.

II. Year 2005 - Concerns:

The Office of the Ombudsperson addressed over **520 issues** involving complaints or concerns regarding the Department of Mental Retardation (DMR) for calendar year **2005**. This total does not include ongoing cases or current projects. This Office showed a **17.4% increase** in cases reviewed when compared to the previous year's total of 443 concerns.

As noted above, the Office of the Ombudsperson was established in the latter part of June 2001.

The following years total number of concerns is listed in the table below:

Year 2001, first six months of activity	Concerns 110
Year 2002	Concerns 220
Year 2003	Concerns 355
Year 2004	Concerns 443
Year 2005	Concerns 520

As the below charts indicate, this Office has seen a steady increase in cases reviewed in each year of operation. I have listed the areas of concern that this Office monitors. Some categories were eliminated because the number of instances, with regard to the total sum, were negligible. Section IV: Comprehensive Monthly Statistical Report shows the total number of concerns for each month broken down into specific categories for the calendar year. The total number of cases reviewed and any percentage increase versus the previous year's cases is exhibited in Section V: Percentage increase of concerns.

III. Areas of Concern:

During the past year the Office of the Ombudsperson reviewed **520 concerns/ complaints/issues** endemic to the DMR. Concerns were divided into **16 categories**,

- **Abuse/Neglect**
- **Budget**
- **Case Management**
- **Day Programs**
- **Dental Services**
- **Eligibility**
- **Employment**
- **Forensics**
- **HIPAA**
- **IFS Waiver**
- **Information & Referral**
- **Medicaid Benefits**
- **Respite**
- **(Residential) Placement**
- **Self-Determination**
- **Transportation**

IV: Comprehensive Monthly Statistical Report for 2005

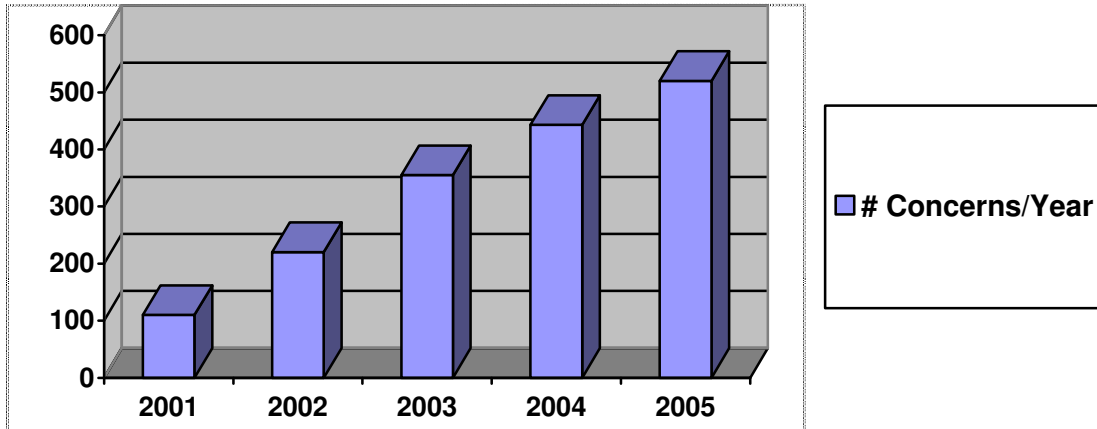
Client Concerns	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	% TOTAL
Abuse/Neglect	1	3	3	1			1		1	1	2	1	14	2.69%
Employment									2		2	1	5	0.96%
Budget					4	4	2						10	1.92%
Case Management	4	4	4	3	4	4	4	7	5	6	4	6	55	10.58%
Day Programs	2	1	3	2	3	3	2	2	5	3	4	3	33	6.35%
Dental Services	2	2	2	1	1	1	1	3	2	1	4	1	21	4.04%
Eligibility	3	1	3	4	5	5	2	5	3	4	2	3	40	7.69%
Forensics									2				2	0.38%
IFS** Waiver				6							2	3	11	2.12%
Information & Referral	9	13	15	17	19	19	11	19	18	15	17	11	183	35.19%
HIPAA*											4	6	10	1.92%
Medicaid	3	4	4	4	1	1	1	2					20	3.85%
Placement Inquiry	3	5	5	4	6	6	4	7	5	4	6	3	58	11.15%
Respite	1	1	3	2	1	1	1	3	3	2	2	2	22	4.23%
Self-Determination	2	2	2	1	4	4	2	4	3	4	3	2	33	6.35%
Transportation											3		3	0.58%
TOTAL REVIEWED	30	36	44	45	48	48	31	52	49	40	55	42	520	100.00%

*HIPPA: Health Insurance Portability and Accountability Act

**IFS: Individual and Family Support

V: Percentage increase of concerns per year

Concerns



Year ->

*2001 is for first six months of operation

This Office saw a 100 percent increase in concerns when comparing its first half year of operation in 2001 to its first full year of operation in 2002. From 2002-2003 there was a 61 percent increase in concerns. 2003-2004 saw a 25 percent increase, and 2004-2005 a 17 percent increase in concerns filed with this Office.

VI. HIPPA

The Office of the Ombudsperson complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by requiring the use of signed release of information forms when requests for assistance requiring third person involvement come into the Office.

The HIPAA law protects health information from disclosure, which offers privacy protection to individuals regarding their medical records. (Please see Appendix A for a more detailed explanation of HIPPA).

VII. Year in Review for the Department of Mental Retardation:

The DMR and the consumers it serves saw many changes in 2005. Significant highlights include:

- The settlement of the Waiting List Lawsuit resulted in guarantees of funding for five years through the Waiting List Initiative. New funding for the DMR Waiting List and enhanced family supports annualizes to \$8 million in each of the fiscal years starting with FY 04-05. The initiative is to serve 150 people each year for five years who are on the Waiting List and to provide another 100 families with enhanced family support.
- Approval of the Individual & Family Support Waiver (IFS Waiver) was developed to enhance individual and family supports. The Individual and Family Support Waiver was authorized to provide direct services and supports to people who live in their own home or family home. It is approved for individuals who do not require 24- hour paid supports. Services and supports are organized into four categories:
 1. Home and Community Supports
 2. Day/Vocational Supports
 3. Ancillary Supports
 4. Additional support services

To view the entire IFS Waiver manual, <http://www.dmr.state.ct.us/HCBS/index.htm>

- Anyone receiving or applying for residential placement through the Department of Mental Retardation (DMR) or receiving services or supports from DMR must enroll in Medicaid and the department's Medicaid waiver programs to be eligible for funding.
- Enrollment in Medicaid, and applicable Medicaid Waivers, is a condition for commencing and continuing an individual's placement, support, or services and eligibility for placement. It allows for the DMR Commissioner to provide services, within available appropriations. (The Commissioner may make exceptions to the enrollment requirements in certain limited conditions.) Anyone whose excess income or assets make him ineligible for Medicaid can remain in his placement or continue to receive DMR supports and services if he is implementing a DMR approved "Asset Reduction Plan" until qualified. See PA 05-280 (HB 7000) Section 31 "AN ACT CONCERNING SOCIAL SERVICES AND PUBLIC HEALTH BUDGET IMPLEMENTATION PROVISIONS." EFFECTIVE DATE: July 1, 2005. <http://www.cga.ct.gov/2005/ACT/PA/2005PA-00280-R00HB-07000-PA.htm>
- One new respite center opened in 2005. The Department of Mental Retardation now has a total of 10 respite centers in public settings. These centers are capable of serving over 1000 families per year and are staffed by 125 trained respite providers.

This year the department received funding for an additional 20 case managers in the legislative budget. As these positions were being filled along with many vacancies, there was a degree of movement within the system causing changes in caseloads.

In most instances, this occurrence caused a change in the consumers' long-standing case manager. Many families contacted this Office asking for assistance when the relationship between case manager and consumer was in jeopardy of changing.

This Office consulted with consumers and families to help in the transition. Some families sought assistance to keep their current case manager. In these instances, this Office spoke with the families and worked with the region on a case-by-case basis to determine within the scope of available resources whether their current case manager could be maintained. When this was the case, the region worked to keep that individual on the case manager's caseload.

Once all these new positions are filled the caseload sizes will be reduced.

VIII. 2005 Accomplishments of the Office of the Ombudsperson

The Ombudsperson resolved some major concerns, gained support for existing initiatives, began work on new programs and received new appointments in 2005.

Some of the initiatives of the Office of the Ombudsperson:

- **Transportation** -This Office has been concerned with and looking into the condition of DMR's fleet since late 2002. Reviewing the status and mileage of all vehicles used by the DMR to safely transport its consumers remained a priority. The Office began to review this problem when families contacted this Office asking why mechanical repairs for DMR fleet vehicles, especially wheelchair accessible vans, took an inordinate amount of time to complete. Families were concerned that the time it took to repair vehicles could cause consumers to miss their day programs and other activities for an extended period of time. This Office found that the solution to this problem was not an easy one to identify, as the maintenance of fleet vehicles is performed by service technicians in two fleet garages, owned and maintained and by the Department of Administrative Services (DAS).

To resolve this problem, the Ombudsperson's Office collaborated with DMR's business office and discussed what the major problems were and how best to correct them. Finally, we requested a meeting with the Department of Administrative Services, (DAS) staff to discuss ways to rectify the timeliness of fleet repair. Once our concerns were listed we went to work to correct the problem. Those concerns included:

- 1. The number of vehicles currently in the shop for mechanical or body repair**
- 2. The number of wheelchair vans, mileage and years of service**
- 3. The average length of time vehicles are in for repair**
- 4. How or if the delays affect client services, day programs, and if additional vehicles are available to use when current ones are down**
- 5. The fiscal impact**

Collectively, it was agreed that repairs were taking longer than expected. However, it was also agreed that safety was often cause for the delay. Not only must a vehicle be repaired but it must also be thoroughly checked for wear and obsolescence. The additional time spent was deemed a necessity before transporting any consumers in these vehicles to assure safety.

The DMR determined, after many meetings, that other options needed to be explored. The safest approach to this recurring repair problem was to request funds to replace and in many cases add new vehicles to the Department of Mental Retardation's fleet.

After lengthy analysis it was agreed that funding for **56 new vehicles** would be approved by the Office of Policy & Management. (OPM). Collaboration between DMR, DAS and OPM resulted in long-needed improvements to the DMR fleet.

The following summarizes the number of vehicles purchased for each region:

- West Region- **22 wheelchair vehicles.**
5 additional wheelchair vans and 17 replacement wheelchair vans.
- North Region- **14 wheelchair vehicles.**
13 replacement wheelchair vans and 1 replacement wheelchair bus.
- South Region- **20 wheelchair vehicles.**
14 replacement wheelchair vans and 6 replacement wheelchair buses.

The total of the Department of Mental Retardation's additional and replacement vehicles is:

5	additional wheelchair vans
44	replacement wheelchair vans
<u>7</u>	replacement buses
56	Total Vehicles

- The improvement of **Oral Health Care** for individuals with mental retardation has always been a priority of this Office. The Office of the Ombudsperson initiated a number of activities to address this growing problem for people with disabilities, specifically individuals diagnosed with mental retardation. This office found that the lack of access and availability, (i.e. a limited number of dentists who would accept Medicaid XIX), for dental services for individuals with mental retardation is a concern that could no longer be overlooked. For several years this office has advocated both statewide and nationally for programs that will lead to better coverage for individuals with mental retardation.

The Council on Mental Retardation determined at the beginning of the legislative session that this was the year to lobby its legislators for improved access to dental care for individuals with mental retardation. The Council explained that dental care, in some cases, was nonexistent for persons with mental retardation. Its tireless advocacy was responsible for **Public Act 05-213***. Hopefully, this Act will promote awareness of the fact that much more work is needed toward the goal of improving Oral Health Care for our most vulnerable population.

*** PA 05-213 (HB 6819) AN ACT CONCERNING ACCESS TO ORAL HEALTH CARE.**

This bill revises the scope of practice for dentists, dental hygienists, and dental assistants, including establishing conditions under which licensed dentists can practice oral and maxillofacial surgery. It allows a candidate for a dentist's license to substitute a year of post-graduate training for the practical portion of the licensing exam and provides a way for foreign-trained dentists to become licensed as dentists or dental hygienists. And it creates continuing education requirements for dentists. <http://www.cga.ct.gov/2005/act/Pa/2005PA-00213-R00HB-06819-PA.htm>

- **VISIT-ABILITY (Inclusive Home Design)**

Visit-ability is a movement to change home construction practices so that virtually all new homes--whether or not designated for residents who currently have disabilities--offer a few specific features that make the home easier for people who develop a mobility impairment to live in and visit.

The overall goal is to develop a model "Visit-ability Community" in New Britain in the affordable housing rehabilitation project to be developed by CPS Properties and the Connecticut Housing & Finance Authority (CHFA). This "visit-able" project will allow its residents to "age-in-place."

This office formed a coalition to assist families needing simple accommodations to get into and out of their home or apartment so that their children could leave the home for inclusive education. After being contacted by the Connecticut Children's Medical Center for Children with Special Needs (CCMC), it was evident that a long-term plan needed to be established for families who have children with special needs to assist them in moving freely within their homes and communities.

The coalition is made up of members of CCMC, U.S. Housing and Urban

Development (HUD), Office of Projection and Advocacy (OPA), Corporation for Independent Living, Capital Region Education Council (CREC), Rebuilding Together Hartford, a member of the Department of Mental Retardation Individual and Family Support Council, and the Independent Ombudsperson for Mental Retardation.

Most importantly, this workgroup was established to make it possible for individuals with the diagnosis of mental retardation and other disabilities “age-in-place” with their families.

Goals and Objectives:

The basic goals for each new housing unit include having one entrance with no steps, 32” of clear passage through all interior doors including bathrooms, and at least a half bath (preferably a full bath) on the main floor.

Visit-ability Objectives:

The pilot program will serve five families with accessibility needs, providing them greater access, increased independence for family members with disability needs, preservation of family and individual dignity. In turn this will improve parents’ ability to return to the workforce because children’ accessibility needs have been met, and allow individuals to “age-in-place” with their families.

Pilot housing developers will be provided with “Simple Design” solutions that may reduce the number of parents’ injuries due to lifting, etc.

Family and fiscal benefits of the Pilot will include the reduction of children having to be placed in group homes and/or hospitals and a reduction in Home Tutoring Special Education costs as more children with disabilities will be able to leave their homes for inclusive school programs. This will improve family preservation. Housing preference lists will be reduced and Homeland Security measures will be expanded by providing safer environments for individuals with disabilities.

Plan of Action:

1. Committees will be established, tasks assigned and activities reported monthly at Team meetings.
2. Co-Chairs will continue to meet with “Players” and encourage our participation in the planning process, etc. (meeting with CHFA, etc.)

Some of the Appointments of the Ombudsperson:

- Re-appointed by President Bush to serve on the President's Committee for People with Intellectual Disabilities (PCPID).
- Re-appointed to serve as a Commissioner on the Commission on Human Rights and Opportunities (CHRO), an appointed position approved by the General Assembly.
- Assist the Office of the Governor in statewide activities regarding the Americans With Disabilities Act (ADA).

IX. President's Committee for People With Intellectual Disabilities

A. Sub-Committee for Employment

As a member of the President's Committee for Persons with Intellectual Disabilities (PCPID) and Chairperson to the Sub-Committee for Employment, I advocated on a national level for the following:

- Establishment of Qualified Disability Savings Accounts (QDSA) for individuals with intellectual disabilities and their families to promote long term planning and savings to advance personal and economic freedom.
- Asset Development for persons with Intellectual Disabilities. The approval of an annual waiver through Social Security Administration (SSA) and the Centers for Medicare and Medicaid Services (CMS) that provides incentives to work and accumulate assets for persons with intellectual disabilities without losing their eligibility for benefits. In Connecticut, individuals may apply for this program with the Department of Social Services under the provisions of Public Act No. 05-44, AN ACT CONCERNING THE DEFINITION OF HUSKY PLAN, PART A AND THE AVAILABILITY OF SERVICES UNDER THE HOME AND COMMUNITY-BASED WAIVER PROGRAMS, which is also known as Medicaid for the Employed Disabled. <http://www.cga.ct.gov/2005/ACT/PA/2005PA-00044-R00SB-01157-PA.htm>
- Establishment of a strategic partnership with US Department of Labor & Commerce, Equal Employment Opportunity Commission & Department Of Transportation to promote employment for persons with intellectual disabilities.

B. Dental Access Subcommittee

As a member of the President's Committee for Persons with Intellectual Disabilities, I also serve on the subcommittee for dental access for persons with intellectual disabilities. The dental care focus subcommittee includes input from a number of key resources and specialists in the field of dentistry and disability. Members of this subcommittee include: Dr. Stephen Pearlman, D.D.S., M.Sc.D. Global Clinical Director, Special Olympics Special Smiles; Dr. Stephen Corbin Dean, Special Olympics University; Matt Holder, MD, MBA Executive Director – American Academy of Developmental Medicine and Dentistry Global Advisor for Medical Affairs – Special

Olympics International; Julie Allen, Manager, Legislative and Regulatory Policy American Dental Association; and Sanford J. Fenton, D.D.S., M.D.S., Professor and Chair, Pediatric Dentistry, University of Tennessee.

This subcommittee is working to provide specific recommendations to the Secretary of Health and Human Services and the President along with a formal statement for implementation. After consulting with PCPID staff, it appeared that no new legislation would be necessary, however, there were questions regarding whether regulatory changes would be needed. Hopefully, this work will result in a recommendation to the President for increased resources dedicated to improving oral health care for persons with mental retardation (MR) / intellectual disabilities (ID), MR/ID.

The PCPID has recently examined the current state of dental care for persons with MR/ID. Though there are significant and appalling disparities experienced by people with MR/ID in accessing quality dental care, the PCPID believes that implementing a strategic, multi-faceted plan designed to address the underlying problems of dental care finance, provider training and public awareness will do much to improve the overall quality of health for all Americans with MR/ID.

Through its inquiries, the PCPID has identified three major areas of deficiency: finance; professional knowledge; and public awareness. Improvements in these areas would lead to better oral health for people with neurological disorders and individuals with a diagnosis of MR/ID. (Please see Appendix B for more on Dental Access for people with MR/ID)

X The Office of Ombudsperson's Objectives for 2006:

- Continue statewide and national advocacy for improved dental care for persons with mental retardation.
- Continue to work on behalf of consumers with significant issues with DMR service provision including: Dissatisfaction with Placement, Waiting List, IFS, Comprehensive Waivers. Communicate these needs to the Commissioner of DMR.
- Continue to work on upgrading the DMR wheelchair accessible fleet and increase wheelchair vehicle access for consumers.
- Continue Visit-Ability pilot in New Britain and identify other communities in which the pilot could be expanded.

XI Appendix A-HIPPA Overview

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important new - but limited - protections for millions of working Americans and their families. HIPAA may:

1. Increase your ability to get health coverage for yourself and your dependents if you start a new job;
2. Lower your chance of losing existing health care coverage, whether you have that coverage through a job, or through individual health insurance;
3. Help you maintain continuous health coverage for yourself and your dependents when you change jobs; and
4. Help you buy health insurance coverage on your own if you lose coverage under an employer's group health plan and have no other health coverage available.

Among its specific protections, HIPAA:

1. Limits the use of pre-existing condition exclusions;
2. Prohibits group health plans from discriminating by denying you coverage or charging you extra for coverage based on your or your family member's past or present poor health;
3. Guarantees certain small employers, and certain individuals who lose job-related coverage, the right to purchase health insurance; and
4. Guarantees, in most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance policy.

XII Appendix B-PCPID Activity on: Dental Services for People with MR/ID

Approximately **70 percent** of people with MR/ID participate in the Medicaid system. Unfortunately, in many states, Medicaid does not cover dental care for adults except for emergency situations (see Appendix: Dental Charts). Low reimbursement rates for Medicaid deter many dentists from accepting Medicaid patients. Additionally, dentists who do accept Medicaid patients are unlikely to accept patients with MR/ID because these patients may take up to twice as long to treat due to factors such as behavior control and/or chronic oral neglect.

In most states, children under the age of 21 have fairly comprehensive access to Medicaid financed dentistry. However, once they reach the age of 21, these individuals often suddenly find themselves without adequate access to dental services.

Until 2005, no dental school was required to teach dentists to treat people with MR/ID. In 2005 the Council on Dental Accreditation (CODA) under pressure from the American Academy of Developmental Medicine and Dentistry (AADMD) and other organizations adopted a measure that requires all dental schools to train dental students to be competent in assessing the treatment needs of people with MR/ID. Recently, the American Academy of Developmental Medicine and Dentistry (AADMD), through a grant from Special Olympics and the Centers for Disease Control (CDC), performed a comprehensive national survey of medical and dental education in the United States regarding people with MR/ID. In this study, despite the fact that up to 6 million people in the US have MR/ID, it was found that the majority of dental schools do not consider this to be a priority subject,. It was also found that once dentists are fully trained, the number of those selecting continuing education focusing on MR/ID is extremely limited.

Unfortunately, public awareness of the healthcare plight of people with MR/ID is also very limited. Studies by the Special Olympics show that the general public believes that individuals with MR/ID receive the same or better healthcare as other people living in the United States. In a recent survey screening athletes from Special Olympics with an average age of 24, it was found that nearly one in eight people with intellectual disabilities had a pain causing lesion in their mouth, one in six had untreated decay, and one in four were already missing teeth.¹.

Recommendations: *Write a letter of request to the Branch Designation Office of the Health Resources and Services Administration (HRSA) requesting that people with MR/ID be considered as a Medically Underserved Population (MUP).*

Ramifications: The MUP designation will allow the National Institutes of Health (NIH) and other granting institutions to consider the MR/ID population as a legitimate population for programs such as Health Disparities Research, Medical and Dental Loan Repayment Programs and J-1 Visa, Foreign Graduate Programs. Such programs will promote research interest in this population as well as provider and university interest. The MUP designation has been applied at the state level (in Illinois), however, **should be applied on a national level.**

In order to improve the quality of dental services available for people with MR/ID living in the United States, the PCPID has identified a number of initiatives to be undertaken. It is important to note that the problems leading to the general lack of access to quality dental services for people with

MR/ID are very complex. It is also important to note that the PCPID believes that many of the issues affecting dental care similarly affect the quality of medical care available to people with MR/ID.

A more comprehensive and systemic approach to improving the overall health of people with MR/ID would also include similar initiatives designed to affect the medical field.

¹See the Status of Adult Medicaid Dental Services, State-by-State in Appendix C.

References

Corbin, SB; Malina, K; Shepard, S. Special Olympics World Summer Games 2003, Healthy Athletes Screening Data, Washington, D.C., Special Olympics, Inc. February 2005.

Conclusion: Improving the quality of dental and medical services available for people with MR/ID living in the United States is crucial, and the PCPID has identified a number of significant initiatives toward that goal. The PCPID has also identified a number of key organization and individuals who are knowledgeable regarding healthcare and healthcare training for people with MR/ID.

XIII-Appendix C

Adult Dental Medicaid Coverage – A State-by-State Overview
American Dental Association

ADULTⁱ DENTAL BENEFITS IN MEDICAID: FY 2000, 2002, 2003, 2004 & 2005											
	00 ⁱⁱ	02 ⁱⁱⁱ	03	04	05		00	02	03	04	05
Alabama	None					Nebraska	Limited				
Alaska	Emergency					Nevada	“Palliative”				
Arizona	Lim	Emergency				New Hamp	Emergency				
Arkansas	None					New Jersey	Full				
California	Full					New Mexico	Full			Lim	
Colorado	None					New York	Full				
Connecticut	Full					N Carolina	Limited				
Delaware	None					N Dakota	Full				
Florida	Lim	Emergency				Ohio	Limited				
Georgia	Emergency					Oklahoma	Em erg	Non e	Emerg		
Hawaii	Emergency					Oregon	Limited				
Idaho	Lim	Emergency				Pennsylvania	Full				
Illinois	Limited					Rhode Island	Limited				
Indiana	Full		Limited			S Carolina	Emergency				
Iowa	Full	Limited				S Dakota	Limited				
Kansas	Limited					Tennessee	Emergency				
Kentucky	Limited					Texas	None				
Louisiana	Limited to dentures + pregnant women					Utah	Li m	Emergency			Lim
Maine*	“Urgent” Care					Vermont	Limited				
Maryland	Emergency					Virginia**	None				
Mass	Full	Limit ed	Emerg			Washington	Full		Limited		
Michigan	Full		Emerg/ limited.			W Virginia	Emergency				

Minnesota	Full	Limited	Wisconsin	Full		
¹²Mississippi	Emergency		Wyoming	Emergency		
Missouri	Limited	no ne	Dist of Col	None		
Montana	Limited					
As of May 2005						
Key:	Full	“Limited” iv	“Emergency” y”	“None”	“P”= Proposed	“U”= Proposed, but Unlikely

Status of Adult Medicaid Dental Services, State-by-State

Alabama: No dental services for adults.

Alaska: Dental services limited to relief of pain and treatment of infections associated with fillings and extractions.

Arizona: Dental services limited to emergencies, medically necessary dentures, and pre-transplant services. Proposal to eliminate all adult dental care has been made.

Arkansas: Dental services are limited to treatment of life-threatening conditions.

California: Governor had proposed elimination of all dental services beginning in the 4th quarter 2003. The proposal, however, gained no momentum among lawmakers; adult services remain intact. An across-the-board 5 percent reduction appears to be likely for all providers in January 2004. Initially, the governor had proposed elimination of all dental services beginning in the 4th quarter 2003. The proposal faced legal challenges and then stalled. Then in early 2004, the governor took all specific proposals for Medicaid off the table when he proposed that the entire Medi-Cal program be redesigned. That process has been in effect for several months now and results are expected to be presented in January 2005.

Colorado: No dental services for adults.

Connecticut: **Periodontia, fixed bridges, and several other services are not covered. State planned to eliminate adult care, redirecting funds to a new children’s dental care model. The planned elimination of benefits for 23,000 adults was blocked on March 31, 2003, by issuance of a temporary restraining order. Dentists fervently edified their elected officials on the negative ramifications of adult cuts. The proposed service reduction has been quelled; adult services remain as they were prior to the proposed cuts, at this writing.**

Delaware: No dental services for adults.

Florida: Effective July 2002, adult benefits are limited to medically necessary, emergency dental procedures to alleviate pain or infections (i.e., emergency examinations, necessary radiographs, extractions, and incision and drainage of abscesses). Governor’s 2003 budget does not include any funding for dental services, but legislature may not agree and indeed may add back some adult dental services (dentures). A 2005 enactment eliminated expiration of adult Medicaid dental service program.

Georgia: Dental services are limited to emergency services such as limited examination, related x-rays, extractions, and surgical procedures related to pain, infection or trauma.

Hawaii: Dental services are limited to palliative and emergency care, including extractions, incision and drainage, some surgical services and medically necessary emergency services.

Idaho: Effective April 2002, only emergency services included for adults.

Illinois: No preventive services, or periodic exams available for adults.

Indiana: \$600 cap on expenditures, effective March 2003, excludes surgical procedures and two periodontal services. Denture/partial fees were reduced by 50%. Some of the non-covered codes were effective November 2002 (same time rates for dentures and partials were reduced); other eliminated codes are dependent upon a rule change to take effect June 2003. (Dentures added back as a covered service for adults with prior authorization – as of 9/03)

Iowa: Effective March 2002, adult care is limited to exams, x-rays, amalgam/composites, dentures, partials, bridges, and oral surgery. Eliminated services include: crowns, posts and cores, periodontal, endodontic and orthodontic services.

Kansas: Dental extractions with associated exam and x-rays are covered for adults, if medically necessary.

Kentucky: Coverage is limited, but includes oral exams, emergency visits, x-rays, extractions, fillings, for all ages. Root canal therapy, crowns, sealants and braces (for severe malocclusions) are limited to eligible recipients under age 21 meeting prior-authorization criteria. Dentures and partials are not covered. Denture repair, limited to recipients under age 21. Elimination of dental coverage is being discussed for July 2003.

Louisiana: Only dentures, denture relines and denture repairs are covered. Examination is covered, if in conjunction with denture construction. Added extended dental services for categorically eligible pregnant women as of 2/04.

Maine*: GAO categorized Maine adult dental care in 2000 as including “full” benefits; however, this may have been overstated, or in error. The basis benefit package remains: adults “receive selected procedures as necessary to relieve or eradicate acute pain, control bleeding, eliminate acute infection and prevent imminent tooth loss. Adult dental care procedures do not include ongoing comprehensive dental treatment, treatment of the dentition and gingiva, and routine treatment of incipient decay.” Adults with “qualifying medical conditions also may receive services, including dentures. (From Section 25.04.1, MaineCare Benefits Manual).

Maryland: No emergency or other dental care included in the state-operated fee-for-service program; however about 90% of adult Medicaid beneficiaries are enrolled in the HealthChoice managed care organizations which may provide a variable degree of emergency, preventive and other dental services.

Massachusetts: Effective March 15, 2002, Massachusetts eliminated preventive and restorative services for adult MassHealth members. Adults were then covered for emergency services (includes oral surgery) and prosthetics. Also, adults having a severe disability, for example, could be designated (for three years) as “Special Circumstances” (SC) which entitles them to continue to receive preventive and restorative services. There are currently 20,000 members designated as SC. Effective January 1, 2003, adult prosthetics was eliminated for adults, except for those designated with SC, and the MassHealth Adult Dental Program became an Emergency Only Program.

Michigan: October 1, 2003 marks a substantial cut dental services for adults, leaving only emergency services, such as exams, x-rays and extractions; this action ends non-emergency dental care for Medicaid beneficiaries 21 and over. About 600,000, including low-income mothers, destitute nursing home residents, and developmentally disabled and mentally ill people, will lose routine dental. The adult dental program reportedly cost the state about \$20 million annually. Similar cuts were halted in the early 1990s by a group of dental providers in Ingham County; the county circuit court enjoined dental reductions after evidence showed potential cost increases from adults who would use hospital emergency rooms for dental care.

Minnesota: A comprehensive array of dental services is available currently. On April 8, 2003, a budget revision was introduced in the legislature to eliminate all but preventive services and dentures for adults, with a limit of up to \$500/year.

Mississippi: Emergency care for the relief of pain and infection including emergency extractions, palliative care, and dental care related to treatment of an acute medical or surgical condition. Dental care for pregnant adults was reduced.

Missouri: In August 2002, a court issued a temporary injunction halting a planned reduction in adult dental services that was to begin July 2002, and would have retained only dentures and services related to dental trauma. The Governor’s proposed budget for 2003 eliminates adult dental services; however, on March 18, 2003, the legislature passed emergency funding to continue the dental program, as enjoined, through 2003. Signed into law April 2005, S 539 eliminates adult dental services in Medicaid.

Montana: Beginning February 2003, dental service for adults was reduced to emergency dental services only. This reduction, which affected 70,000 adults, was a temporary measure that was reversed in 2003. Although the adult dental program has been restored (with some limitations) effective July 1, 2003, it is anticipated that inadequate funding will lead to significant reductions to the adult program at some point during the coming biennium if the number of adults eligible for Medicaid services remains at the present high level.

Nebraska: Adult coverage is fairly comprehensive and covers routine examinations and prophylaxis yearly, preventive services (fluoride, x-rays, sealants) restorations, extractions, endodontics, dentures (complete and partials), periodontal services, and crowns for anterior and endodontically treated posterior teeth. Orthodontic services are not covered. In the fall 2002, the Nebraska legislature passed a bill that ended Medicaid eligibility, including dental services, for 25,350 clients (12,750 adults and 12,600 children). In January 2003, legislation was proposed to reduce the adult benefit to emergency services only. In conjunction with state dentists’ urgings, the

legislature's Health and Human Services Committee, however, sent the bill forward without the provision to eliminate the adult program, and the appropriations committee left money for the program in the Medicaid budget. If the adult program was eliminated it would impact 28,000 adults.

Nevada: Emergency services were limited further in February '02 to include only "palliative care," defined as treatment to control pain, bleeding and infection. Covered services include limited evaluations, x-rays, sedative and temporary restorations, extractions, and fillings/crowns only for abutment teeth for existing partial dentures, and related services.

New Hampshire: Dental emergency services, including extractions, and medically necessary treatments for trauma are covered.

New Jersey: Wide ranges of dental services were saved through an all-out defense program. The New Jersey Dental Association expended a great amount of resources to defend adult dental services in Medicaid. The governor proposed to eliminate adult dental Medicaid early in 2003. Dentists had to educate lawmakers about the value of oral care, and its relationship to overall health.

New Mexico: Services in all categories are available, but endodontics, sealants, and topical fluoride are not generally covered for adults.

New York: wide ranges of dental services are available.

North Carolina: Covered services generally are comprehensive, but preventive services are not available for adults. In 2003, the state has proposed elimination of adult dental services, but the legislature is proposing a different set of cuts, such as elimination of services for the medically needy population. As of this writing, there have been no reductions to dental services in Medicaid.

North Dakota: Medicaid covers exams, x-rays, cleaning, fillings, surgery, extractions, crowns, root canals, dentures (partial and full) and anesthesia. A proposal to eliminate dental services for adults was made, but in the last weeks, the legislature restored basic adult services for the 2003-2005 biennium. Final decisions may not be made until the end of April, 2003. Additional coverage of anterior crowns necessary where endodontics has occurred with prior approval, posterior teeth limited to SS crowns, partial dentures can now include anterior teeth with prior approval, all added as of 10/03.

Ohio: A fairly comprehensive array of services is offered to adults, although topical fluorides and sealants are not available, and periodontal services are restricted. In 2003, the governor proposed to discontinue dental and other optional services in Medicaid order to curb state spending growth. If not for the full dedication of Ohio dentists to educate lawmakers of the residual costs that result from dental cuts, adult services would have been eliminated. The effort from the dental community resulted in the continuation of adult dental services.

Oklahoma: Dental coverage for adults was limited to emergency extractions and reconstructive surgery when medically necessary; however, these emergency dental services were eliminated, effective October 2002. Under SoonerCare Plus, some Medicaid enrollees had some dental benefits; these were eliminated in January 2003. Coverage added back for emergency extractions as of 10/03.

Oregon: A substantial array of services is covered in the "Oregon Health Plan Plus," with some limits. There is a \$3 copayment for restorative, but not diagnostic dental services. Effective March 2003, however, dental services for all "Oregon Health Plan Standard" beneficiaries (adults and children) are eliminated. Oregon restored of some prior benefits that had been cut. Emergency dental, and some medical equipment will be part of the standard package. The changes affect only the 50,000 people on the standard plan, not the 300,000 people on the plus plan.

Pennsylvania: Dental coverage is comprehensive.

Rhode Island: Dental coverage for adults is limited in the areas of endodontics, fixed prosthodontics, and orthodontics.

South Carolina: Adult coverage is limited to emergency services.

South Dakota: Covers exams, X-rays, cleanings, fillings, and provides limited coverage for endodontics, crowns, partial dentures, complete dentures and anesthesia.

Tennessee: Adult coverage is limited to emergency services.

Texas: No coverage for adults, except for dental services which are provided by a dentist who is functioning as a physician, and then only for services that are secondary to a life-threatening medical problem.

Utah: Effective June 2002, adult dental services were limited to emergency examinations, x-rays and extractions for the relief of pain and infection. A 2005 enactment states the legislative intent is to restore Medicaid adult dental services. A spokesman for Gov. Jon Huntsman Jr. (R) called the restoration of funding one of the governor's chief health care priorities.

Vermont: Services include emergency dental care for relief of pain, bleeding and infection, selected preventive and restorative procedures rendered to limit disease progression, and necessary diagnostic and consultative services.

Services not covered include sealants, periodontal surgery, comprehensive periodontal care, orthodontia and prosthodontics, however the denture benefit was eliminated September 2002. There is an annual benefit maximum of \$475 per person.

Virginia:** GAO categorized Virginia adult dental care in 2000 as including “partial” benefits; however, this may have been overstated or in error. Virginia covers dental services only when the service is covered under Medicare; Medicare specifically excludes services connected with the dentition or structures supporting the dentition. Emergency dental services are not covered. Dental services related to an underlying medical condition may be covered.

Washington: In July 2003 the state eliminated most dental benefits, maintaining partial dentures and preventive services. The Washington State Medicaid program sent a letter to the state's dental providers and stakeholders, requesting feedback on a restructured adult dental program that fits new operating budget for the 2003-05 biennium.

West Virginia: Dental coverage is limited to emergency services only, i.e., emergency examination and associated x-rays, along with incision and drainage, or extractions.

Wisconsin: The state currently has comprehensive dental services.

Wyoming: Coverage is available for emergency relief of pain and/or infections and includes limited oral evaluation, palliative treatment, extractions, and excision and drainage.

District of Columbia: No dental services are covered for the adult population.

ADULT DENTAL BENEFITS IN MEDICAID: 50 STATES & Dist. of Columbia FY2000 - CY2005 As of May 2005					
BENEFIT STATUS	2000	2002	2003	2004	2005
Full	14	12	8	7	7
Limited	17	14	16	18	18
Emergency	13	17	18	19	18
None	7	8	9	7	8