

Testimony: Dr. Jane Gillette, DDS, MPH

6.30.20

There is a section in MCA that allows hygienists to obtain special permits from the Board of Dentistry to provide specific limited hygiene services (i.e. tooth cleanings and fluoride) in certain settings outside of the comprehensive team-based care model of a typical dental office or clinic. The intention of the statute is obviously to provide a mechanism for care to people who otherwise wouldn't be able access to care. It's intended to be limited because it's a deviation from the professional standard of care.

Specifically, the statute sets out standards in determining eligible locations and persons: "The provision of services under a limited access permit is limited to patients or residents of facilities or programs who, due to age, infirmity, disability, or financial constraints, are unable to receive regular dental care."

The legislature defined what they believed to be public health facilities, and therefore sites where services could be provided. Those sites are community health centers, migrant farmer worker clinics, health clinics for the homeless, nursing homes, group homes for the elderly, disabled, and youth, and local public health clinics. What all of these places have in common is that they meet the standards outlined in the statute I just read previously. They all have patients or residents who have a reasonable likelihood that due to age, infirmity, disability or financial constraints, are unable to receive comprehensive, continuous, team-base care.

The legislature debated, and ultimately decided not to include in this statute, public schools. They decided that schools are not public health facilities. That's sort of obvious. They're places of education and have students, not patients or residents. But they also decided, that public schools have diverse enrollment in which both low-income and high-income are educated together under the same roof.

The legislature has thought through this many times very carefully, and each time, has decided not to include schools, because public schools do not meet the intent, letter, or spirit of the statute.

Nevertheless, there is a section in the statute that allows for the Board of Dentistry to, on a case-by-case basis, to designate a non-listed place as a site where care can be provided. For example, many years ago Paris Gibson Alternative School was adopted as a place of service on the basis that the school contained a significant proportion of young teenage mothers who were unable to access comprehensive appropriate and necessary care because of the challenges related to balancing parenting, school, and work.

The reason that we're here today is that the Board of Dentistry is taking action to develop standards for adopting schools as places for the delivery of services. However, the Board of Dentistry does not have authority to develop their own standards. The legislature has already

developed those standards (I read them earlier) and those standards are explicitly defined in statute. In fact, Darcy Moe in a 2015 Board of Dentistry meeting, explained to the Board their inability to ad lib and develop their own criteria for adopting categories or groups not explicitly defined in statute.

*From the June 12th, 2015 meeting of the BOD:*

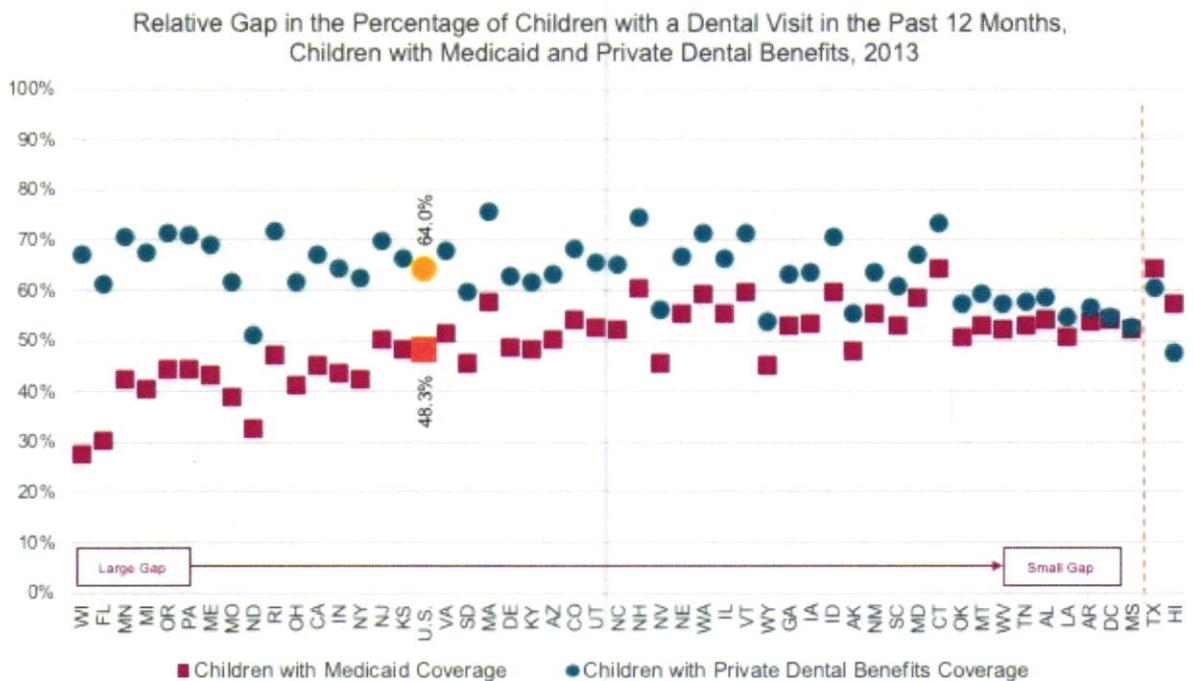
*Porter: Legal counsel (Moe) in DH subcommittee advised the committee that the Board could add schools, but only as long as they fell under MCA which says services are "limited to patients or residents of facilities or programs who, due to age, infirmity, disability, or financial constraints, are unable to receive regular dental care."*

*Porter: Are we (the board) legally able to blanket accept schools? Are we able under the statute?*

*Time 1:48 Moe: Back in 2009, I advised the BOD to go through the statute which is very detailed, MCA does allow for Board to add additional places... The legislature had intent of targeting patients/participants that they wanted to hit with these services, but they also did also give the BOD the authority to go beyond that. And when Paris Gibson was added the Board went through a thoughtful process before including this school as a public health facility. We looked at reasonable necessity for adding Paris Gibson. It's not a normal school. It's an alternative high-school with un-wed mother's. The Board looked at the intent of statute and decided it did fit that criteria and the Board had authority to add it. My legal opinion is because of the detail of the statute and limited amount of wiggle room you have to add these other facilities; I don't believe you have the authority to blanket, say adopt, any sort of facility that's not specifically listed. An example is nursing homes. You have the ability to blanket accept nursing homes, however, if there was different kind of nursing home that wasn't quite a nursing home then you could look at it under the MCA section. Same for schools. It doesn't say schools are included and I don't believe you can add any other **category or group** as a blanket category. I don't think that was intent of legislature or your rule making authority allows that.*

Even if the Board of Dentistry did have the authority to develop their own group or standards, the model and criteria that they are considering would effectively designate a massive number of public schools as places of care. Specifically, the Board of Dentistry is considering using Free and Reduced lunch (FRL) data to designate any school that has 50% of its students enrolled in the FRL program as a public health facility and therefore a site where services could be delivered. This could impact as many 65,000 children across 431 schools in MT. That's about 1/2 of MT schools and Medicaid/CHIP enrolled children in the state. The issue with using FRL data is that the federal government now gives schools the choice to participate in a community-level application process by which any school that has at least 40% of its students who qualify can give FRL to all enrolled students, even the 60% of attending children are high income. So schools in which actually only 40% of their students qualify for FRL now show-up with a FRL rate of 100%.

Again, the intention of the statute was to provide a mechanism for care to people who otherwise wouldn't have access to care. It's intended to be limited because it's a deviation from the professional standard of care. The statute needs to be interpreted narrowly in order to meet its limited purpose, i.e., to allow a mechanism for care in circumstances where care would otherwise not be available. To expand the applicability of the statute beyond its limited purpose to groups that already have access to care in effect improperly – and unnecessarily -- lowers the quality of care that children already receive. And the data confirms that children in public schools overwhelmingly receive appropriate and necessary dental care.



In summary, the Board of Dentistry has overstepped their legislative authority in developing their own standards adopting groups as public health facilities. Those standards and groups have already been defined by the legislature in statute and the legislature has already voted multiple time to not adopt public schools. As such, we're reaching out to ask this committee to help in the enforcement of the intent of the legislature and associated laws.

# Geographic Access to Dental Care: Montana

**79%** OF PUBLICLY INSURED CHILDREN LIVE WITHIN 15 MINUTES of a Medicaid dentist.



**79%** of publicly insured children live in areas where there is at least one Medicaid dentist per 2,000 publicly insured children within a 15-minute travel time.

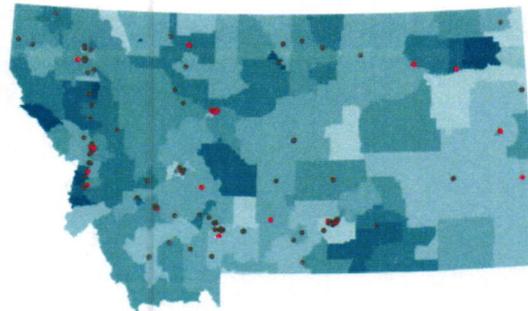


**74%** of the population live in areas where there is at least one dentist per 5,000 population within a 15-minute travel time.

## DISTRIBUTION OF POPULATION ACCORDING TO POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME

Publicly Insured Children per Medicaid Dentist	Population per Dentist
<500	72%
500-2,000	7%
>2,000	0%
No Medicaid dentist within 15-minute travel time	21%
<2,500	63%
2,500-5,000	11%
>5,000	9%
No dentist within 15-minute travel time	18%

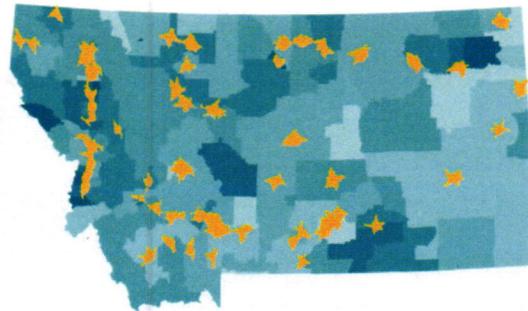
## DENTAL OFFICE LOCATIONS AND PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE



- OFFICE DOES NOT PARTICIPATE IN MEDICAID
- OFFICE PARTICIPATES IN MEDICAID

- PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0-10%
  - 10.1-20%
  - 20.1-30%
  - 30.1-40%
  - 40.1-50%
  - 50.1-60%
  - >60%

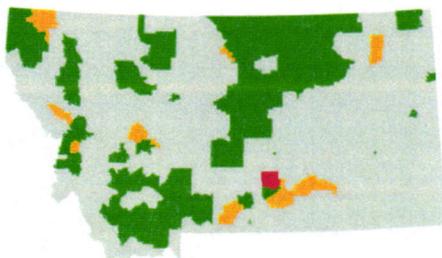
## GEOGRAPHIC COVERAGE OF MEDICAID DENTISTS



- 15-MINUTE TRAVEL TIME TO MEDICAID OFFICE

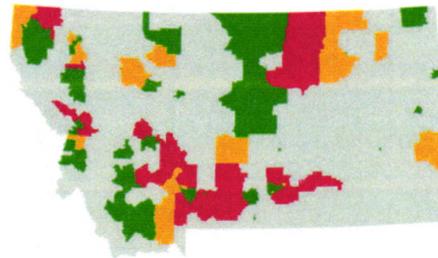
- PERCENTAGE OF CHILDREN WITH PUBLIC INSURANCE
- 0-10%
  - 10.1-20%
  - 20.1-30%
  - 30.1-40%
  - 40.1-50%
  - 50.1-60%
  - >60%

## PUBLICLY INSURED CHILDREN PER MEDICAID DENTIST WITHIN A 15-MINUTE TRAVEL TIME



- NO MEDICAID OFFICE
- <500:1
- 500:1-2,000:1
- >2,000:1

## POPULATION PER DENTIST WITHIN A 15-MINUTE TRAVEL TIME



- NO DENTAL OFFICE
- <2,500:1
- 2,500:1-5,000:1
- >5,000:1

Sources: Based on ADA Health Policy Institute analysis of the 2015 ADA office database and 2011-2015 American Community Survey. For full methodology, see Nasseh K, Eisenberg Y, Vujcic M. Geographic access to dental care varies in Missouri and Wisconsin. *J Public Health Dent.* 2017 Jan 11. Notes: In this infographic, a Medicaid dentist is a dentist who is an enrolled provider in Medicaid or the Children's Health Insurance Program. Percentages in table might not add up to 100% due to rounding. For analyses based on alternative travel time or population-to-provider thresholds, contact [hpi@ada.org](mailto:hpi@ada.org).