Innovative Solutions to the Dental Access Issue

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When I moved to Colorado three years ago, I had recently received my Masters of Public Health at the Rollins School of Public Health at Emory University in Atlanta, Georgia. During my graduate experience, I studied, exhaustively, issues related to overall health and the health care industry. However, never once did my studies delve into the field of dental health, because, as it was noted, "Dental health policy issues are different than for the rest of the health care industry." During that time, I never thought to question this clearly contradictory notion that dental health was not a part of overall health, but rather was a separate entity.

It was not until I began working on dental issues – first, with the Colorado Department of Health Care Policy and Financing and then with the Blue Cross Blue Shield of Colorado Foundation (now Anthem Blue Cross and Blue Shield Foundation) – that I began to wonder why oral health was considered different from overall health. I was stunned to learn the extent of the oral health crisis for low-income populations in Colorado and nationwide, despite tremendous advances in dental technology and a significant overall decline in childhood cavities. I learned that…

- Tooth decay is the most common chronic preventable disease of childhood – five to eight times more prevalent than asthma.
- Across the U.S., 25% of children and adolescents – typically, those from families with low-incomes and minority groups – experience 80% of all dental decay occurring in permanent teeth.
- Failure to prevent dental disease or provide timely and appropriate treatment can result in both long-term social impacts and systemic health complications throughout life – including, poor appearance, low self-esteem, expensive emergency care and treatment, missed school and work days, dysfunctional speech, compromised nutrition and growth, and cardiac and obstetric complications later in life.

When the crisis became so glaringly obvious to me, I set out to better understand the problem and system and to begin to get a better grasp of the how, why, and what could be done to address the problem. Therefore, when the Anthem Blue Cross and Blue Shield Foundation hired me, as a health care consultant, to explore what solutions policy experts and what innovations state dental leaders and policy analysts had come up with to address the dental access issue, I was stimulated by the prospect of this project.

I read the most recent publications related to dental health access, policies, and programs. I searched the web and read Internet list-serve discussions focusing on delivery systems improvements, provider incentives, preventive dental health solutions, and other related topics. I talked to providers, policy experts and dental leaders across the United States to find innovative solutions that other states were achieving success with and were creating an impact – large or small – on improving access to dental services for low-income populations in their respective communities and states.

What I found was a wide range of solutions – some that had been tested, others that had recently been recommended, but were yet to be implemented. What follows is a discussion of several of these solutions and the experiences of states that are putting these solutions into practice – some with success, others with failure.

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Provider Incentives

One of the primary barriers to accessing care is the lack of an adequate provider network to deliver services to low-income families and children, including those eligible for publicly funded health programs, such as the state's Children's Health Insurance Program (CHIP) and Medicaid programs. As such, one of the most common solutions to improve the dental access issue is to create incentives that attract more dental professionals to participate in these programs. These may include: *incentives*, which are positive in nature to entice participation, or *mandates*, which require participation through legal statutes or requirements and are often considered negative.

Incentives

There are many different types of incentives that states are proposing to attempt to increase provider participation in publicly funded health programs. These include:

- Increasing reimbursement rates
- Decreasing administrative burdens for dentists
- Providing loan forgiveness or repayment solutions in return for service
- Increasing flexibility in licensure requirements
- Providing training or continuing education for dental providers
- Increasing the number of pediatric residencies available
- Creating tax credits for providers
- Acknowledging and thanking providers for treatment of the underserved

Reimbursements

Many state and dental policy experts have argued that increases in provider participation occur, only after increasing reimbursement rates to a minimum of 80% of the American Dental Association (ADA) mean (which is 80% of the average cost of all dentists' charges for services for a certain region of the country) or preferably to 80% of the Usual, Customary, and Reasonable (UCR) charges (which translate to 80% of the charges of services by each individual dentist). However, it is reported that the progress is slow and follows a general trend:

- First, there is an increase in the number of dental treatment services provided to children with a prior history of receiving dental care.
- Then, there is an increase in the number of dental services provided to children who have never received dental care.
- Finally, there is a gradual increase in the participation level of dentists enrolled.

Several states have taken this approach with much success in enrolling providers.

In January 1998, ***Delaware*** raised its dental rates from 75% to 85% of actual UCR fees in combination with an aggressive outreach program with the Dental Society to recruit dentists for Medicaid participation. The state Medicaid provider participation increased from one dentist to over 70 dentists in less than 2 years. Delaware will also look at reducing other administrative barriers to further increase participation.

In 1998, ***Nebraska*** also raised its dental Medicaid reimbursement rates to 80% of average UCR. As a result, the state has seen dramatic increases in provider participation, with nearly 750 of 800 licensed dentists participating. In addition, the state is dedicated, not only to raising reimbursements, but also to addressing some of the dentists' other concerns and fixing the overall system.

Another solution is to provide enhanced reimbursements to providers who are seeing a significant number of low-income patients or who are in rural areas, rather than increasing reimbursements across the board.

In ***Utah***, a dentist is reimbursed at an enhanced rate of 120% of the existing Medicaid fee (which ends up being approximately 80% of the ADA mean), if he lives in an urban area and agrees to treat 100 unduplicated patients each year or if he resides in a designated rural community. The results have been mixed. That is, the enhanced reimbursement resulted in a solidification of the providers who were already providing some services and a small addition of new dental providers. Dentists who were seeing some patients, agreed to see more patients, which resulted in a 20% increase in patients seen and procedures being completed. However, the dentists who were seeing only a few patients were discouraged from participating and therefore, discontinued seeing any Medicaid patients. The program is currently in its third year with the enhanced reimbursements. Anecdotally, the program has begun to see a leveling off in the number of services and children being seen. Therefore, they are looking to continue to monitor the progress and determine if other solutions should be taken to further boost provider participation.

South Carolina attempted a similar solution to address the provider access issue. They instituted enhanced reimbursements for dentists who saw 100 children or more annually, which only had a moderate impact on participation rates. Therefore, the state decided to return to a more traditional reimbursement system with fees raised across the board to 75% of UCR. The state will monitor progress and continue to actively work with the Dental Association in an effort to increase the number of dentists participating and increase the number of children seen.

However, some states, like ***Vermont***, rejected this approach because most of their dentists participate, but at low levels of service. Therefore, the state feared that going to a two-tiered payment system would likely give the low participating level dentists a good excuse to discontinue delivering care to this population, as was experienced in Utah. Instead, the additional funds appropriated for fees went to raise reimbursements slightly for all dentists, but the administration and the legislature were very clear that attached to the fee increase was a quid pro quo – "We increase fees, dentists increase volume and access." The State Dental Society agreed. Vermont will be watching the data to determine whether there are increases in volume and access over the next year.

Administrative Burdens

One of the biggest disincentives for provider participation is dealing with complicated administrative processes. This includes using billing systems that:

- Do not incorporate current ADA codes and claim forms
- Do not allow dentists to submit claims electronically
- Do not make timely payments to providers
- Provide complicated and cumbersome eligibility verification processes
- Have burdensome preauthorization requirements

As a result, in order to encourage increased dentist participation, many states are looking to eliminate these barriers so that Medicaid and CHIP claims processing mimics that of private and commercial dental insurance plans.

Pennsylvania has experienced more success in enrolling providers and increasing access to dental care for low-income children in its state Children's Health Insurance Program (CHIP) than in its Medicaid program, because it has addressed these complicated administrative processes. Unlike its Medicaid program, in which there are restricted networks, low reimbursement rates and other administrative barriers, Western Pennsylvania's CHIP uses experienced dental Third Party's Administrators (TPAs) to administer its program. Therefore, the program uses the same networks, reimbursement, billing systems, and eligibility verification processes as in its commercial models, which minimizes the financial disincentives and additional administrative barriers for providers. In addition, children enrolled in CHIP are not singled out. Rather, they receive the same health insurance card as other privately insured individuals, which helps to minimize any potential provider discrimination or stigma associated with being enrolled in a publicly funded program. As a result, the program has had significant successes in increasing access to care and decreasing unmet need. In fact, after 12 months of being enrolled in the program, children's access to dental services improved significantly – the number of children who had a dental visit doubled from 30% to 64%, the percentage of children who had a regular source of dental care increased from 51% to 86%, and unmet dental treatment needs were almost eradicated, from 52% to 10%.

Nebraska is another state that has sought to address complicated administrative barriers in its Medicaid program. In the 1995, the Nebraska Medicaid program attempted to implement capitated dental managed care in three counties. The result was that provider participation dropped because the program increased financial disincentives and administrative barriers for dentists. After this failed attempt with managed care, the Nebraska Medicaid program decided to revamp its program by creating a task force with the Nebraska Dental Association to increase communications between the state and dentists and to begin to eliminate the barriers to their participation in publicly funded programs. The program increased provider rates and initiated a process of reducing administrative barriers, that includes: minimizing the need for preauthorization for most dental services; changing the claims processing to include electronic processing and optical scanning techniques; updating all policies to correlate with ADA procedure codes. In addition, the state has committed to proactively work with the dental association to continue to modify the system to better meet the needs of the dentists, the enrolled clients, and the state.

Vermont has eliminated many of the administrative barriers for dentists, which has resulted in the majority of dentists providing some level of care to Medicaid clients. Vermont has accomplished this by streamlining the claims processing and payment system by using standard ADA billing forms; reducing the number of services requiring prior approval; instituting a rapid electronic payment system, which has cut down on provider payment times; and implementing a simplified eligibility verification process and continuous eligibility that has reduced complications and sped up processes related to eligibility.

Loan Forgiveness

In many states, it is becoming increasingly clear that many established dental providers are not going to sign up with publicly funded programs even with increases in reimbursements or eliminations of administrative barriers. This is, in part, the result of a healthy economy. As such, most dentists can fill their practices with private paying clients that "play by their rules" rather than require them to adapt to someone else's administrative policies. As a result, some states are looking to school loan forgiveness programs as one solution to address the access issue for underserved populations and in Health Provider Shortage Areas (HPSAs). School loan forgiveness/repayment programs offer significant savings to new dentists coming out of school, who are burdened with thousands of dollars in school debt, by providing them with a reduction in these loans in exchange for service to underserved populations.

Maine recently passed legislation for a dental education loan forgiveness and repayment program. The legislation allows for a maximum of $20,000 annually, for a period of up to four years, either in a loan to a current dental student or as repayment for a practicing dentist. In return, loan recipients are obligated to practice in state-designated underserved population areas and "must serve all patients regardless of ability to pay through insurance or other payment source." The intent of the legislation is that these dentists will be working in community health centers or community-based non-profit dental centers, and not in private practice.

Rhode Island has a similar loan forgiveness program for dentists and hygienists, called the State Loan Repayment Program (LRP). The program requires that dentists/hygienists perform a minimum of 2 years of service in a federally designated HPSA. In return, the state pays all or part of the qualifying education loans of the dentist/hygienist, not to exceed $35,000 for each year of service provided. Funding for the program comes from both Federal grants and State matching funds.

Another state, ***Utah***, has a loan forgiveness program that does not require dentists to practice in community-based or non-profit dental health clinics or in Health Provider Shortage Areas. Rather, dentists can apply for their private clinics to be loan repayment sites and then apply for repayment of their loans up to $23,000 for a two-year commitment and up to $73,000 for a four-year commitment. In order to qualify as a loan repayment site, clinics receive points for the percent of underserved, minority and special needs populations treated by their practices and require at least 60% of the practice serving these special populations. However, currently, most sites that have qualified for loan repayments treat in excess of 80% underserved populations.

Although loan repayment has become a solution for many states, other states have several concerns with loan repayment programs. First, often times, the Inernal Revenue Service (IRS) will count any monies disbursed for loan repayment as taxable income, which serves as a huge disincentive for students to participate in this program if they have to come up with thousands of dollars in cash to pay to the IRS. Another issue is that in many states, there are very few designated HPSAs and it is a huge bureaucratic hassle to get a HPSA designation. As a result, there are very few sites where students can go into the loan repayment program. Finally, even if a student is willing to deal with these other issues, because the HPSA designation is so difficult to get, often times only very remote areas with widely dispersed populations are designated. The result is that students may not want to live in such remote deserted communities or may fear that there are too few patients to sustain a practice.

Other

In addition to some of the solutions mentioned above, several states have come up with other incentives to increase provider participation in addressing the dental access issue for underserved populations.

In 1999, ***Michigan and Missouri*** introduced legislation to create **tax credits** to dentists who provide care to underserved populations. Michigan's bill provided tax credits to dentists equal to the amount of uncompensated dental treatment of indigent individuals or $5000, whichever is less. The Missouri bill created a tax credit specifically for those dentists providing services to Medicaid recipients.

In 1998, the ***North Carolina*** General Assembly charged the NC Department of Health and Human Services and the NC Institute of Medicine's Task Force on Dental Care Access to evaluate and recommend strategies to increase the level of participation of dentists in the Medicaid program. Several recommendations that came out of that task force related to providing **training** to dentists and Medicaid recipients; and increasing **pediatric residencies** in the state; and allowing **licensure by credentialing**. One recommendation was to train dental professionals to treat and address the dental health needs of the most vulnerable populations, including minority, pediatric and special needs populations, and to educate Medicaid recipients about the importance of ongoing dental care. Another recommendation was to increase the number of positions in the pediatric residency program at the dental school to thereby increase the number of pediatric dentists in the state, increase the availability, and expand the provision of preventive and restorative dental services for children. The report also recommended the establishment of a licensure-by-credentialing procedure that would license out-of-state dentists and dental hygienists who have been practicing in a clinical setting in other states. The ultimate goal would be to increase the number of qualified dental practitioners within the state and to recruit these dentists to practice in medically underserved areas and for medically underserved populations.

In 1999, several other states passed legislation that increased the **flexibility in licensure requirements**. ***Alabama***, ***Delaware***, and ***Oregon*** passed legislation that accepted out-of-state licenses and/or clinical board examinations of dental providers, including dentists and dental hygienists. ***New York*** passed legislation that eliminated the licensure requirement of citizenship or permanent residence for dentists. In addition, ***Virginia*** passed legislation that allowed for volunteer dentists to obtain a restricted license to practice in free clinics.

A dentist receives an award for excellence in serving the needs of low-income children.

In addition to some of the more "concrete" techniques discussed above, ***Nebraska*** decided that in order to encourage dentist participation in its Medicaid program, it was necessary to **acknowledge and thank dentists** who contribute to the program and provide desperately needed services to low-income, uninsured, minority and special needs populations. The state pays for public service announcements during Public Health Week annually, to thank dentists in the community, and purchases gift certificates and plaques for dentists to acknowledge their efforts to address the dental access issue for low-income populations. Rather than placing blame on the dentists and claiming that they are selfish and uncaring, this creates a positive image of dentists as giving back to the community. As a result, both the state and the dentists feel that this has had a positive impact on the dentists and their willingness to participate.

In addition to encouraging dentists to serve underserved populations and training dentists to become more culturally sensitive to low-income populations, it is necessary to find ways to encourage students from underserved communities to select dental careers. Mentoring programs and active recruitment programs for minority populations need to be further explored. Studies have shown that minority dentists, including African-Americans and Hispanic Americans, disproportionately serve minority and low-income populations. Because these dentists share more social and cultural characteristics with these populations, they better understand their needs, languages, and circumstances. This establishes the mutual trust and respect needed to improve compliance and compatibility between the providers and patients, thereby increasing the likelihood that the dentists will continue to serve these populations.

Mandates

While most states have attempted to approach the provider access issue by using incentives to encourage dentists to participate, one state has taken the opposite approach of requiring dentist participation through mandates, which has had a negative impact on provider participation.

Minnesota has a statute that mandates that all health care providers (including dentists), who treat state and state university employees; employees of certain counties, cities and school districts, whose treatment is paid for by workers' compensation; and a few other small groups of state-covered insureds, open at least 20% of their practices to Minnesota Health Care Programs (MCHP; includes Medicaid and two other state funded health programs). Once a provider's practice reaches this 20% level, they are allowed to turn away any additional MHCP recipients, but not before. This statute has met with much opposition. In 1998, the dentists successfully lobbied to change the law – this lowered their patient threshold to 10%. Even with the change, the statute has not been very effective in increasing dentist participation; rather it has had the opposite effect. This is due to the fact that the law is enforced by complaint only. Therefore, when a MHCP client complains that a provider refused to see them because their practice is already above the 10% limit, an investigation is initiated. These investigations have resulted in the removal of over 100 dentists from the subcontractor list due to violations. As such, the state is now looking at some positive provider incentives to increase provider participation.

Preventive Dental Health Solutions

Because of the inadequate supply of dentists, especially those serving low-income, minority and pediatric populations, several states have begun to look for more proactive solutions to address the dental access issue – to look to prevent, before needing to treat, dental disease. These include using alternative preventive health delivery systems, expanding the roles of other dental health professionals, and creating other innovative preventive health programs to target children before decay sets in.

Expanding the scope of practice for dental hygienists

Though there is much controversy over this issue, some states have looked to expand the scope of practice for dental hygienists to enable them to provide more services without the supervision of a dentist. Some argue that hygienists are not trained to complete some of the new procedures that no longer require a dentist's supervision. Others fear that this new expanded function will take away clients from dentists or will replace dentists in a gatekeeper role with hygienists. Whatever the arguments, some states are exploring this option to see if utilizing more hygienists in public health and preventive settings will begin to help alleviate the dental access issue for low-income populations.

In 1999, ***New Mexico*** passed legislation that enabled hygienists to provide a wide range of oral health services without the supervision of a dentist. These include, but are not limited to: cleaning and polishing teeth; removing diseased tissue; applying fluorides, sealants, and other topical therapeutic and preventive agents; screening to identify indications of oral abnormalities; and providing preliminary assessments of gum disease.

A pilot program initiated in ***Connecticut*** in 1997 that was created to increase access to preventive dental care, particularly for Medicaid and other low-income children, was made permanent in 1999. With an already strong network of school based dental services throughout the state, the program enabled hygienists to practice, within their scope of practice, but without the supervision of a dentist in safety net programs. When the program started as a pilot, a study was conducted to determine the impact of having hygienists practicing in public health settings without supervision and to demonstrate whether it would affect or threaten business for dental practices. The result was that it didn't affect dentists' practices, but rather, in the schools with dental services, it introduced more children to oral hygiene at earlier ages.

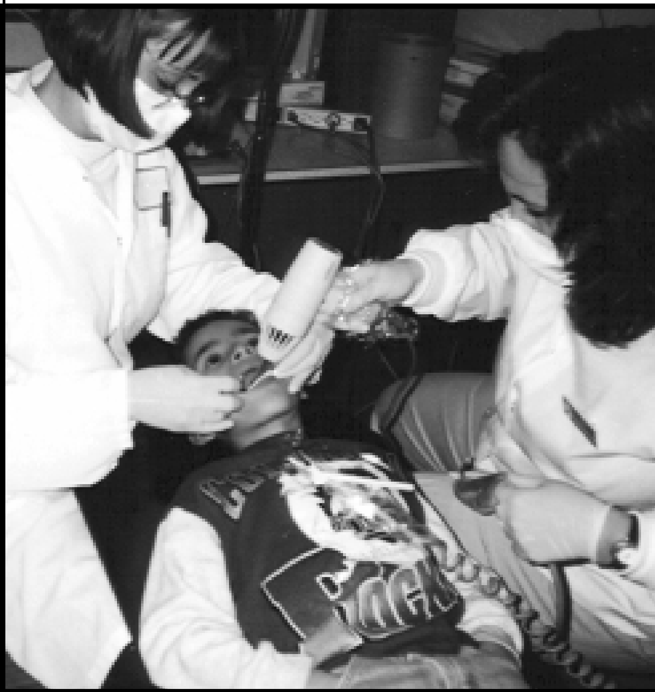
In 1999, ***New Hampshire*** started a pilot program to allow hygienists to practice in school and public health settings to assume a broader scope of duties without a dentist. These duties include screenings, cleanings, fluorides, and referrals, but do not include placing sealants. The goal is to utilize hygienists as case managers for children in public health settings – to introduce these children to dental hygiene, to emphasize the importance of maintaining good oral hygiene, to get them comfortable with the concept of a dental home, and act as a bridge or referral to link children with private practice dentists.

School based and other public health dental programs

Though some states have expanded hygienists' scope of practice in all settings, most states, as mentioned above, have limited this expanded scope to school based and other public health settings.

Connecticut is one such state that wanted to enhance its strong network of school based health services. Of the 54 school based health centers, 20 have school based dental clinics, primarily in elementary schools, with operatories and one or several part-time to full-time dentists providing a comprehensive range of dental services, including, but not limited to, dental sealants. The state has a long history with providing dental services in school, with the first school based dental clinic in the country being opened in Connecticut in 1905. Schools with these dental health services have achieved great successes in increasing access and decreasing decay. In fact, some of the programs decreased dental decay by 20% and the need for urgent care by 38%. The increased role of hygienists in these settings will hopefully help to further increase access and perhaps expand care to other schools as well.

In its task force report to the General Assembly, ***North Carolina*** recommended funding a "Ten Year Plan for the Prevention of Oral Disease in Preschool-Aged Children." The goals of this effort would be to reduce tooth decay by 10% in all preschool children statewide in ten years; and expand the use of public health dental hygienists from school-based settings to community-based settings such as day care centers, Smart Start programs, Head Start centers and other community settings. The program would provide health education to mothers and caregivers, apply fluoride varnishes to young children, use dental sealants when appropriate, and provide continuing education courses for any professional who has contact with young children. The program would extend the benefits of North Carolina's school-based preventive dentistry programs to preschool children. North Carolina's school-based programs have had a significant impact on elementary and middle school children since beginning operation in the early 1970's. The program currently reaches over 300,000 children annually and has decreased dental decay in permanent teeth of school children by 50% since the program was started. North Carolina hopes to find funding in the near future for this preschool program to complement its existing school based program and begin to address the limited availability of services for preschool children.



Finally, ***Washington*** has created an innovative preventive dental health program to address the oral health needs of low-income children less than six years of age that has become a model for other states. The program, known as ABCD, or Access Baby and Child Dentistry, is a dental simulation of Medicaid's EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) program. The program encompasses many of the solutions discussed earlier in this paper, including providing enhanced payments to participating dentists who provide an array of dental services for enrolled children; providing education and case management to enrolled clients related to appropriate clinic behavior and proper oral hygiene; providing continuing education to providers related to delivering care to pediatric, low-income, and special needs populations; and thanking and acknowledging dentists who contribute to the dental well-being of enrolled children in their communities. In addition, however, the program creates strong links to the existing medical establishment for young children. The program ties fluoride and preventive dental health treatments with immunizations and other medical services; trains EPSDT and other pediatricians to deliver preventive dental health screenings and services, such as fluoride varnishes to children; and creates a referral network between physicians and dentists to ensure that children receive both the proper medical and dental attention and services that they need to grow up healthy.

Conclusions

This is not an exhaustive list of innovations to the dental access issue for medically underserved populations, but it represents a wide variety of the solutions that states are implementing to address the issue. While many states are just beginning to implement these and other solutions, it will be necessary to:

- Watch the effects of these innovations,
- Evaluate and determine whether they are successful,
- Apply the successful models, and
- Continue to search for other modifications and completely new interventions to address the dental access issue for low-income populations.

However, states must be willing to be proactive in finding solutions and willing to change in order to continually improve and modify the system to address the inequalities faced by most low-income populations in accessing oral health services. As Reuben C. Warren, a dentist and dental health policy expert, wrote, "As long as oral health services are isolated from other health and human services, and oral health is perceived as separate from general health, underserved groups will continue to prioritize oral health as important but not urgent, or desirable but expendable." It is necessary for state government and health policy experts to actively modify the existing system to successfully integrate oral health services.

References provided upon request.
Contact Carmen Fujinami at 303-831-2810.

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