ORAL HEALTH POLICY IN KANSAS AND MISSOURI

By Jessica Hembree

Introduction

Although we tend to think about medicine and dentistry as separate components of "health care," they are inextricably linked. Poor oral health can have dramatic impacts on overall health, leading to poor nutrition, cardiovascular disease, low birthweight babies, and diabetes.

Dental caries (tooth decay and cavities) is the leading childhood illness. Nearly 59% of U.S. children experience dental caries, more than asthma or hay fever.[1] By the time Kansas kids reach third grade, 58.6% of them have had dental caries. Among Missouri third graders, 55.3% of them have had dental caries. For nearly half of these children, the caries go untreated.[2] Access to regular, preventive care in childhood is the key to reducing dental caries and establishing solid dental hygiene practices that will preserve a healthy mouth into adulthood. Only 60.7% of children in Kansas aged one to five received preventive dental care in the past 12 months. This compares to 56.1% in Missouri and a national average of 58.8%.[3] In Kansas City alone, over 90,000 low-income children are not receiving preventive dental care.[4]

Medicaid/SCHIP Coverage

Many residents of Kansas and Missouri lack access to employer-provided dental insurance. Less than 40% of Missouri employees have dental health insurance.[5] Very low-income residents of Kansas and Missouri qualify for Medicaid, which offers some dental benefits. The two charts in the appendix provide a graphic representation of the dental benefits provided under state Medicaid and SCHIP programs. Both Missouri and Kansas' Medicaid programs are required to provide comprehensive dental care to children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The federal government requires that Medicaid fund regular screenings and necessary treatment for Medicaid-enrolled children.[6]

Dental Screenings

The State of Kansas passed a statute in 1912 requiring schools to provide dental screenings to students on an annual basis. The law is not enforced or funded.

The Kansas Department of Health and Environment Oral Health Initiative is in the pilot year of an initiative to revive annual, school-based dental screenings. In the first year of the project, 30,000 children received screenings.

Adults, on the other hand, have very limited access to publicly provided dental care. The majority of adults on Medicaid are only given access to dental care in emergency situations. Both Kansas and Missouri have opted to provide dental benefits to select adult populations.

Kansas offers dental coverage to adults who are eligible for Medicaid under home and community-based services waivers due to:

- physical disability
- developmental disability

- head injury
- frail elderly

Missouri provides dental coverage for Medicaid recipients who are in the eligibility categories of:

- pregnant women
- blind
- nursing home residents

The 2005 Medicaid cuts ended dental coverage for the vast majority of adults receiving Medicaid in Missouri.[7] In Kansas, 75,000 adults who qualify for Medicaid do not have dental coverage.

A very small fraction of Medicaid expenditures in the United States are for dental care. Nationally, dental care accounts for only 2% of total Medicaid expenditures.[8] In Missouri, Medicaid spending for dental care accounts for less than 1% of total Medicaid expenditures.[9]

Unfortunately, many of the children who are eligible to receive dental coverage through Medicaid or SCHIP still do not receive needed services. In 2003, 45% of Missouri children hospitalized for preventable dental conditions and 53% of children who visited emergency rooms for dental related illness were MC+/Medicaid recipients.[10] At the national level, 80% of tooth decay in children occurs in Medicaid and uninsured populations.[11]

Finding Dental Care Providers

One of the most significant barriers to dental care for Medicaid/SCHIP-eligible children is the lack of dentists willing to accept Medicaid patients. Only 15% of practicing dentists in the Kansas City area accept MC+/Medicaid patients. As a result, there are 923 low-income children in the greater Kansas City area for every one dentist willing to treat them.[12]

Of Missouri's dentists, only 30% accept Medicaid patients.[13] Of Missouri's 115 counties, there are 44 without a dentist willing to accept MC+/Medicaid.[14] Head Start programs are required to assist participating children in finding a dental home. Due to the shortage of dentists willing to see Medicaid patients, a child in Missouri's Head Start program waits an average of 6.5 weeks for a dental appointment.[15]

Volunteer Dentists

Safety net providers often rely on volunteer dentists. Both Kansas and Missouri have state-sponsored funds that support the liability and malpractice insurance of dentists and hygienists that work in charity settings.

Many of these volunteer dentists are retired. The Missouri Dental Association is supporting a retired licensure status that will reduce annual licensure fees for dentists that provide pro bono care.

In Kansas, 45% of dentists are enrolled in Medicaid and 23% are enrolled in SCHIP. Only 29.7% of all Kansas dentists had filed a Medicaid claim in the past year and 19% had filed an SCHIP claim.[16]

Dentists cite low reimbursement rates, high administrative burdens, and patient behavior as three major reasons for choosing not to accept Medicaid patients.

In Missouri, oral health care services are reimbursed at approximately 40% of the costs of treating patients.[17] The low reimbursement rates provided by Medicaid are especially difficult for dentists to absorb because they have higher administrative costs than most doctors. More than 92% of dentists are in private practices and 79% are sole proprietors, making overhead and administrative costs high. Overhead costs average about 60 cents of every dollar, making it even more difficult for dentists to accept the low reimbursement rates offered by Medicaid and SCHIP.[18]

Doctors and Dentists

Since overall health includes oral health, doctors can play an active role in ensuring the oral health of their patients. At a minimum, doctors can provide a cursory visual screen of teeth and refer parents and children to a dentist for care. The simple process of doctors reminding parents about the importance of oral health would result in increased preventive care.

Missouri recently passed legislation allowing doctors to be reimbursed for providing fluoride varnishes to Medicaid children.

Of Medicaid patients, 30% fail to keep their appointments.[19] The Missouri Foundation for Health and Health Care Foundation of Greater Kansas City recently published "State Strategies to Improve Dental Compliance in Missouri's Medicaid Population." The publication notes that many states address the issue of missed appointments in the context of larger dental reforms. Other state strategies that can be undertaken outside of comprehensive dental reform are: case management/care facilitation; focused follow-up contact to clients with missed appointments; coordination with primary care; transportation; and education and outreach.

Today it costs about $300,000 to educate a dentist and $100,000 to educate a hygienist.[20] Many oral health providers finish their graduate education with significant debt, which makes it even more difficult to take jobs in public settings or even to accept Medicaid patients. Missouri supports the Health Professional Loan Repayment Program which provides forgivable loans for primary care physicians, dentists, dental hygienists, and mental health professionals who work in health professional shortages areas. Loan recipients gain forgiveness by working in an area of defined need. The program is funded through a federal match.[21]

Rethinking the Delivery of Dental Care

Aside from increasing or redistributing dentists, some policies focus on expanding the role of dental hygienists and assistants. Under the traditional model of dental care delivery, dentists must be on site, offering supervision of a dental hygienists' work. More and more states are increasing the responsibilities of dental hygienists and even giving them the authority to work independently of dentists. In Kansas, hygienists with more than three years of experience and continuing education can receive extended care permits (ECPs) that enable them to provide preventive dental care to students,

inmates, clients and patients who are eligible for Medicaid, SCHIP, and/or free and reduced lunches (<185% FPL) in community settings, provided they are sponsored by a licensed dentist. These preventive services include teeth cleaning, the application or fluoride varnishes, and other services that the sponsoring dentist permits.

There are about 1500 dental hygienists in Kansas, of which only 90 to 100 have an extended care permit. Many of these hygienists are connected with safety net clinics or dental hubs. This model was originally intended to give hygienists the opportunity to be entrepreneurial, however ECP hygienists cannot directly bill Medicaid for services delivered. Instead, ECP hygienists are usually affiliated with a safety net clinic or health department that bills Medicaid on their behalf.

A few years ago, Missouri passed legislation that allows hygienists with three years of experience who are affiliated with a Federally Qualified Health Center or government health program to provide certain preventive dental care, including teeth cleaning and the application of fluoride varnish, to Medicaid-eligible children in schools and child care centers. However, hygienists can't be reimbursed by Medicaid for these services, creating an unworkable law. This legislation could be expanded on in many ways: including hygienists associated with safety net clinics and local public health agencies; allowing the provision of services to low-income children and adults; and increasing the locations where services can be provided.

Some states have increased their reliance on doctors for the delivery of preventive treatment and oral screenings. Engaging pediatricians to deliver oral health services to very young children is sensible since parents are likely to begin taking their child to a pediatrician at a very young age whereas most parents don't take their child to a dentist until the child has reached the age of three or older. By this time, many children, particularly at-risk young children, already have advanced tooth decay.[22] The American Academy of Pediatrics recommends that dental care begins very early on in a child's life by working with pregnant women to establish a dental home before a child reaches the age of one.[23]

Dental Hubs

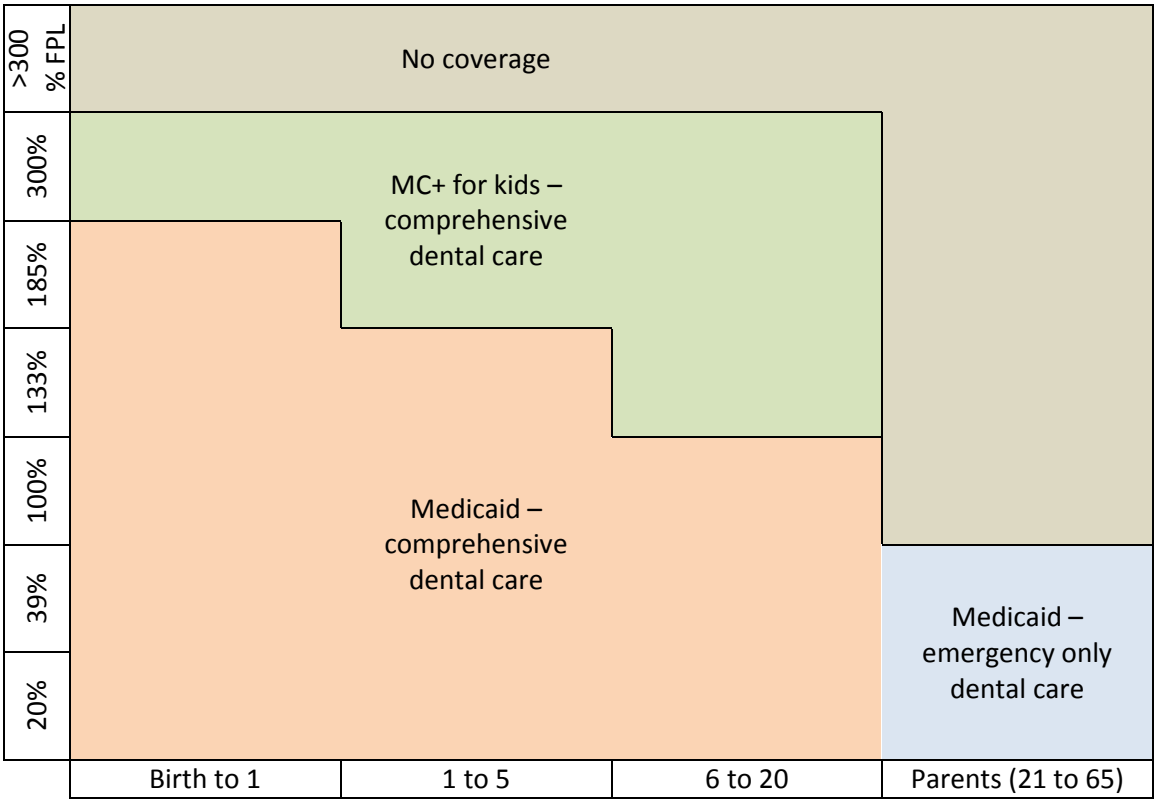
The dental hub model is one in which a clinic that offers dental services acts as the center of the hub, sending dentists or hygienists into community settings, such as nursing homes, child care centers, and schools, to provide preventive dental care. These providers are the "spokes" of the dental hub wheel. If they detect serious oral problems that require restorative care, they refer patients back to the dental hub.

There is some discussion of adding new dental professionals with responsibilities somewhere between a dental hygienist and a dentist. The only place where such professionals are currently operating is Alaskan Indian reservations. Alaska has authorized "Dental Health Aide Therapists" to operate in remote areas. The therapists are under the general supervision of a dentist meaning that they are closely affiliated with a dentist, but the dentist need not be physically present for the therapist to deliver care. The Alaska therapists rely on electronic information exchange to provide x-rays to dentists. The therapists then talk with dentists via phone to develop a treatment plan.[24] Minnesota very recently

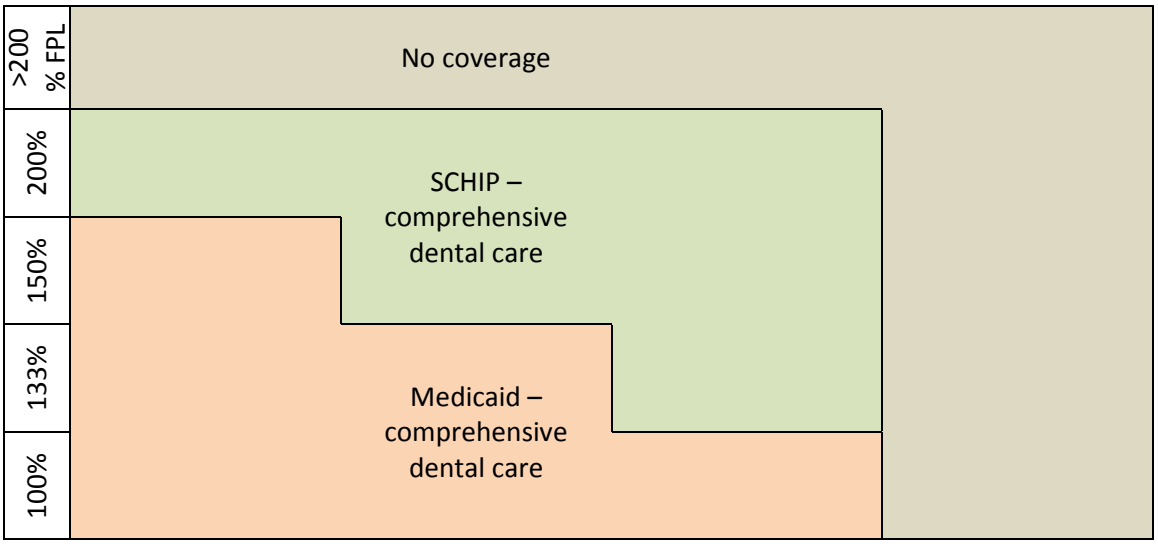
authorized the creation of Oral Health Practitioners that work collaboratively with dentists to provide preventive and restorative dental care. The pilot program will not take effect until 2011.[25]

Appendix A

Missouri: Oral Health Coverage through Public Programs[26]



Kansas: Oral Health Coverage through Public Programs[27]



37%				Medicaid – emergency only dental care
	Birth to 1	1 to 5	6 to 20	Parents (21 to 65)

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