Oral Health Care and Methods to Increase Effectiveness of Dental Healthcare in Kansas

There has been much discussion regarding the oral health landscape in Kansas. This report will examine key issues that Kansas faces in regards to oral health and the state’s dental healthcare system. Among the questions being addressed are:

- “Dental Deserts” - areas or populations in Kansas that are underserved
- The low number of Medicaid dental providers
- The current Extended Care Permit.
- The proposed Registered Dental Practitioner license proposed in HB 2280 and SB 192.

Dental Deserts
A study conducted by the University of Kansas Medical Center for Community Health Improvement found that there are key issues that Kansans face regarding oral health. For example, in 2009, 54 percent of practicing dentists in rural counties were planning on retiring in the next three to five years with most not having interested buyers of their practices. These rural providers accept Medicaid patients at a much higher percentage than their urban counterparts. But 93 of Kansas’ 105 counties, or 88 percent of our counties, face dental workforce shortages. (Kimminau, 2011)

This KU Medical Center study identified three populations who are currently not being served by the oral health system. These groups are:

- People who cannot easily travel for services (frail and elderly) and those with limited mobility
- Those without dental insurance who cannot pay out-of-pocket
- Medicaid enrollees who cannot find a dental provider willing to accept patients with public reimbursement

The study also identified geographic areas that lack primary care dental offices -- A Dental Access Desert. The five counties in which people currently have a 30-minute or longer drive (the definition of a Dental Access Desert) to reach their primary care provider are Gray, Wallace, Comanche, Barber, and Ness counties. The study also predicted that many more areas will become Dental Deserts in the near future because of the increasing retirement rate of dentists in the coming years. This means that there are currently 57,000 Kansans who live in Dental Care Service Deserts with that number growing in the coming years (Kimminau, 2011).

Medicaid Reimbursement
Currently, Kansas is one of the 33 states to provide some form of Medicaid reimbursement for oral health services provided by primary care providers. The state of Kansas currently reimburses $17 for each application of fluoride varnish, but it does not reimburse the primary care provider for any other services (Cantrell, 2009). Washington State has begun an
innovative program in which providers are reimbursed for both an oral exam/screening and caregiver education; a combined reimbursement of $57.04 for the two services as opposed to the $13.25 reimbursement for just the application of fluoride varnish. The study noted that reimbursing all of these services as a combined sum has been “instrumental in increasing medical provider participation in Medicaid reimbursed fluoride varnish application (Hanlon, 2010).”

Though required by the Early and Periodic Screening, Diagnosis and Treatment Program, The National Academy for State Health Policy has found that only 1 in 5 Medicaid-Enrolled children receive regular screenings or the treatment needed from medical, dental, or vision providers. Many dental providers are reluctant to become Medicaid providers because the reimbursement rates are often well below the cost of providing the service. Furthermore, care-seeking behavior among Medicaid recipients is low and there is a high no-show rate for dental appointments. This is likely due to burdensome program administration requirements that are not required by other insurance carriers and lack of patient education (Borchgrevink, 2008).

There have been improvements in the state run Medicaid programs of specific states. Examples include Michigan, which entered into a Managed Care Organization (MCO) contract with Delta Dental in 2000 to administer to children in non-urban communities. The state pays Delta per enrollee per month but Michigan sets reimbursement rates for Medicaid providers at 100% of Delta Dental Premier rates. In each of the states examined in the study conducted by The National Academy for State Health Policy, reimbursements were increased to cover more than the administrative cost and this saw increases in Medicaid participation among providers from 62 percent to 150 percent (Borchgrevink, 2008).

Nationally, most states’ Medicaid payment rates are substantially below market rates, and below the cost of producing care itself. A national analyses shows that average national Medicaid reimbursements for dental care are $14-$20 per member per month while premiums run $17-25 per member per month (Crall, 2011). But, raising rates can be a two-step process that sees a two-fold increase in the cost for the state. First, the state is paying more for the services through reimbursements provided, sometimes even doubling payment for services so reimbursements align more with the dentist’s usual rates. Next, if the state is successful in attracting more dentists and expanding the coverage, expenditures will rise further (Borchgrevink, 2008).

However, dental spending is under two percent of total Medicaid spending. Even with large growth in expenditures, it will still be a relatively small part of spending compared to other services such as nursing home care or prescription drugs. Increasing this dental care as part of Medicaid spending would only bring dental Medicaid spending closer in line to national dental health expenditures of five percent of total spending (Cantrell, 2009).

But it is important to note that access to dental care is not entirely dependent on spending. A majority of experts interviewed in a study conducted by the National Academy for State Health Policy said that adequate reimbursement rates (meaning rates that at least met the overhead expenses) were necessary, but not sufficient to improve access to Medicaid dental services (Borchgrevink, 2008). Dentists frequently cite frustrations with broken appointments among Medicaid patients and administrative hassles as significant problems when working with Medicaid users.
The Extended Care Permit

The Kansas Extended Care Permit was created in 2003 to improve access in these underserved locations. While some Extended Care Providers (ECPs) have been delivering services in underserved locations, very few worked in the most underserved locations.

Currently, an Extended Care Permit can be obtained by Dental Hygienists with varying levels of the permit with different tasks and responsibilities:

- **Extended Care Permit I** -- 1,200 hours of dental hygiene care within the past three years
  - Practice of dental hygiene may be performed with the consent of a parent or legal guardian on children in non-private practice settings
  - Removing stains and debris from teeth
  - Application of topical anesthetic if the hygienist has completed a required course
  - Application of fluoride
  - Dental hygiene instruction
  - Assessment of patient's need for further evaluation by a dentist

- **Extended Care Permit II** -- must have 1,800 hours of practice in the past three years under the supervision of a dentist and 6 continuing education hours on the care of special needs patients
  - All the tasks of ECP I
  - May perform practice of dental hygiene in community setting or in dental clinics without the presence of a dentist.
  - May provide hygiene service to persons with developmental disabilities and on persons who are residents in an adult care home, elderly in subsidized housing, hospital long-term care unit, state institution.

- **Extended Care Permit III** -- must have 2,000 hours of practice in the past three years under the supervision of a dentist
  - All the tasks of ECP I and II
  - May practice dental hygiene on children who are considered to be dentally underserved (Oral Health Kansas, 2010)

Currently, there are 35 dentists per year influx in the state and The University of Kansas Medical Center for Community Health Improvement recommends an increase in the number of dentists becoming newly-licensed in Kansas. Other suggestions include acquiring additional seats from neighboring dental schools such as UMKC, University of Nebraska/College of Dentistry, Creighton University, and the University of Oklahoma College of Dentistry. The study also suggests increasing the community involvement such as state loan repayment programs (such as KIND) that not only repay student loans for new dentists working in under-served areas but also provide funds for office costs/start-up for dentists as part of local economic development. Another idea is to require that new dentists fulfill a social obligation role such as requiring that they participate in Medicaid and take Medicaid patients.

**Proposed Legislation (HB 2280 and SB 192)**

This continuing lack of access to dental services has led to the push for Registered Dental Practitioners (RDPs) in House Bill 2280 and Senate Bill 192. But the question remains, if these RDPs are licensed, how can they be most effectively placed in underserved areas and with underserved people? In House Bill 2280 and Senate Bill 192 which are currently being debated, Dental hygienists (who are licensed and have an Associates degree) could complete an additional 18 months of training to become Registered Dental Practitioners.
These RDPs would be supervised by Dentists in one of two types of supervision: direct and general. Under direct supervision, the RDP would work in the same setting as the Dentist and under general supervision, the RDP would work in a different setting after receiving permission from their supervising dentist.

The services that a RDP may provide include all of the services that Registered Dental Hygienist provides plus additional services such as fillings, cavity preparation, extraction of loose permanent teeth, extraction of already loose baby teeth, and perhaps most importantly, the ability to diagnose and refer patients to dentists for further treatment.

The bill stipulates that RDPs would have to meet one of the following conditions: work at a safety-net clinic; be employed in federally designated workforce shortage area; or work at a private practice in which 20 percent or more of the revenues come from Medicaid (HB 2280 and SB 192, 2013).

The National Academy for State Health Policy has identified three methods for preventively improving oral health:

- **Oral Examination/Screening/Risk Assessment** - Primary care physicians who are trained to identify signs of dental disease during a child’s routine well-child check-up and then referring them to a dentist.
- **Anticipatory Guidance/Caregiver education** - Primary care providers along with dental providers can serve as oral health advocates and educators during visits.
- **Application of Fluoride Varnish** - A study from the Wisconsin Medicaid program found that allowing providers to be reimbursed for applying fluoride varnish increase the application in 1-2 year old children. This is a quick and easy procedure that can be administered by auxiliary staff and integrated into the well child visit.

The mid-level providers specified in HB 2280 and Senate Bill 192 could potentially address these approaches outlined by the National Academy for State Health Policy. But would it fix the oral healthcare problems Kansas is facing?

**Conclusion:**
There are clearly many issues at hand here and not all problems can be solved with a single solution. Lack of access can take multiple different forms (geographic, monetary, etc.) and a multi-pronged approach is needed to address them. The main questions to consider in reviewing HB 2280 and SB 192 are:

- **Quality of care**
  - Is the training of RDPs adequate to maintain the level of care we are accustomed to?
  - Are there particular procedures that are best left to dentists?
- **Fiscal Considerations**
  - How much does it cost to train RDPs with programs being developed at Fort Hays State University?
- **Placement:**
  - The Extended Care Provider is a mid-level that has seen varying results. What can be done to ensure that RDPs are placed in underserved areas and work with underserved populations?
  - Can Kansas achieve the same goals by improving the Extended Care Provider by better placing these mid-levels, as well?
References:


Kansas House of Representatives. Committee on Health and Human Services. HB 2280. 2013

Kansas State Senate. Committee on Ways and Means. SB 192. 2013

Kimminau, Kim and Anthony Wellever. *Mapping the Kansas Rural Dental Workforce: Implications for Population Oral Health*. University of Kansas Medical Center for Community Health Development. September 2011