

Access to Care for Iowa Children, and the “Dental Home”  
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Iowa’s Dental Home Legislation

“By December 31, 2010, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home.”

Dental Home Definition

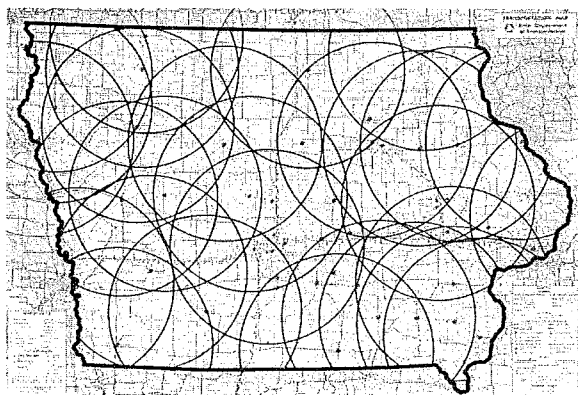
“The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate.” - American Academy of Pediatric Dentistry Reference Manual (2008-09)

Iowa Has Unique Strengths

1. Highly educated population (rank = 14)
2. Low poverty level (rank = 42)
3. High Water Fluoridation (>90%)
4. Good distribution of dentists (n=1546)

“Rural - not remote”

<http://www.allstays.com/c/walmart-iowa-locations-map.htm>



5. High Medicaid participation by dentists:
  - a. 69.3% had claim last year (n=1,072);
  - b. 38.3% were reimbursed over \$10,000 (n=592)
6. Good Distribution of Pediatric Dentists accepting Medicaid (>90%)
  - a. Absolutely essential because they are the only group of providers with the training, ability and comfort to provide care to the children who have the most difficult time finding access to care, including:
    - i. Children under school-age (0-4) with caries
    - ii. Medically compromised children
    - iii. Children needing sedation or general anesthesia for their care
    - iv. Children with severe/profound special needs
  - b. Ave. Medicaid reimbursement per Pediatric Dentist in 2008 >\$100,000
7. High number of school-age children report having a dentist
  - a. 2006 statewide oral health survey of school children:
    - i. 91% have a dentist
    - ii. 69.7% have been to a dentist in the past six months
8. State-Funded Dental School (class size 80)
9. Iowa is one of the “healthiest” and “best” places to live (rank = 6)

In summary – Iowa is a relatively healthy state with a strong infrastructure for delivery dental care to its citizens.

Access to Care Still a Challenge for Some Iowans

In order to have access to care, Iowans need to be able to:

1. Get to a dentist who has capacity and is willing to see them
2. Pay for services

Iowa can succeed in improving access to care for the “Dental Home” population (Medicaid-enrolled children 12 and under) using the following approach:

1. Fund Medicaid to adequate levels

Comparison of current fees:

Code	Procedure	College of Dentistry Fee	Iowa Medicaid Reimbursement	%
00120	Recall Exam	\$ 50.00	\$ 16.63	33.3%
01120	Prophy	\$ 50.00	\$ 24.95	49.9%
01206	Fluoride	\$ 34.00	\$ 14.55	42.8%
00272	2 BW x-rays	\$ 40.00	\$ 16.63	41.58%
	Total:	\$ 174.00	\$ 72.76	41.82%

- There has been no serious effort to address this issue, and despite minor increases in reimbursement from time to time, the percent of UCR continues to decrease annually

- While increases would require additional state expenditures, it is important to understand that the total Medicaid budget for Dental Care is extremely low (~3%).
2. Continue to fund care coordination
    - One of the strongest components of the I-Smile program.
    - Necessary due to high failure rate of Medicaid patients compared with other patients. Also necessary to evaluate and reduce other barriers to care (transportation, language, etc.).
    - Medicaid patients have higher rates of broken appointments than non-Medicaid patients, particularly in private practice settings.

Iben, P., Kanellis, M.J., Warren, J. Appointment-keeping behavior of Medicaid-enrolled pediatric dental patients in Eastern Iowa. *Pediatr Dent*, 22(4): 325-9, 2000.
  3. Change Medicaid administration – to look like other insurance companies
    - Same paperwork, same insurance claim forms, etc.
    - From a business perspective, patients will look the same
  4. Establish loan repayment plan for dentists willing to practice in shortage areas.
    - Graduating dentists have heavy debt load (\$150-200,000 common)
    - Private practice – not public health clinics
      - Following loan-repayment obligation, private practice remains
    - Require Medicaid participation
    - This is an investment in Iowa Communities, not just in Medicaid
      - Important to stop “brain drain” from Iowa
  5. Physicians and physician-extenders provide oral health screenings (part of EPSDT exam) for all Medicaid-enrolled children.
    1. Apply fluoride varnish on children with teeth 0-3
    2. Refer all children to a dentist at one year of age
  6. Public Health settings should employ dental hygienists who should work to the full extent of their scope of practice (e.g. child health clinics, WIC clinics, etc.)

Additional Cost-Effective Ideas

1. Establish program and licensure to allow expanded function dental assisting
  - a. EFDA = placing restorations, carving restorations, essentially all reversible procedures
  - b. Increases capacity of current infrastructure
  - c. Quick start up

- d. Low cost
  - e. Win-win-win-win for patient-practitioner-EFDA-Iowa
2. Regular meetings of leadership of key organizations in Iowa, to discuss access and other issues concerning the oral health of Iowans
  - a. Iowa Dental Association
  - b. Department of Public Health
  - c. College of Dentistry
  - d. Iowa Board of Dental Examiners

### Cautionary Notes

#### 1. Utilization vs. Access

Need to be careful not to confuse the two. Many children have access to dental care but do not have parents willing to take them. Thus the key role of care-coordination.

Example: Head Start programs have a very difficult time getting parents to comply with taking their kids to the dentist

#### 2. Program Evaluation

When evaluating programs, should measure changes in disease rates – not just number of program activities

Examples: Since “caries” is the disease, we should measure changes in “untreated decay” rates, not just the number of exams or fluoride varnish treatments provided; Since finances are a concern, should look at “total money spent”, not just compare costs of preventive treatment to restorative treatment

#### 3. Populations Left Un-Served

Be aware of populations who will not be helped by I-Smile:

- Low income children who are not eligible for Medicaid (children of undocumented workers)
- Medicaid-enrolled and eligible children whose parents do not comply with recommendations (example: kids who have multiple OR appointments for restorative dentistry)
- Working poor who do not have dental insurance and cannot afford care
- Low income adults (large numbers visit hospital ER for dental problems)