I-Smile
The Iowa Dental Home Proposal

3/2/06

I-SMILE EXECUTIVE SUMMARY

Background	Iowa House File 841 states: *By July 1, 2008, every Medicaid recipient who is a child 12 years of age or less must have a designated dental home.*
Rationale	Less than 45 percent of all children enrolled in Medicaid have a dental visit during a year. Low-income children are most at-risk for severe and untreated decay. Treatment of severe decay for children ages birth to three often requires hospitalization and costs can range from $2,000-$5,000. Tooth decay can be prevented; prevention must begin at an early age. Early access to preventive dental services for children has shown significant cost savings compared to delayed access in later years.
Dental Home	The American Academy of Pediatric Dentistry's definition of a dental home is the conceptual framework in this proposal. The I-Smile proposal consists of a dentist, supported by a network of dental and non-dental public and private healthcare providers providing preventive and care coordination services. These services include screenings, preventive therapies, education, and referrals for dental treatment by a dentist.
Current Obstacles	There are an insufficient number of practicing dentists in Iowa, particularly in lower-income and rural parts of the state—79 counties are estimated to be designated dental shortage areas. Many dental practices are very busy and do not accept *any* new patients, especially if patients cannot pay at current market rates. The majority of general practice dentists are uncomfortable or unwilling to see children under age three. Dentists are reluctant to accept Medicaid-enrolled patients due to low reimbursement and poor dental appointment compliance issues. Enrollment of children into the Medicaid program is increasing at an average rate of 1 percent per month.

I-SMILE PROPOSAL

Improve the Dental Support System for Families	Medicaid-enrolled children and families need assistance receiving timely oral health care and locating dentists who will treat children in Medicaid. Strategies to support families in accessing a dental home for their Medicaid-enrolled children include: • Strengthening the dental infrastructure of local Title V Child Health agencies to focus on children's oral health and provide oral health care coordination, • Improving care coordination through improving data tracking systems, • Using dental hygienists as oral health coordinators within Child Health agencies for preventive care, education, care coordination, and referrals to dentists, • Increasing oral health education for families, • Providing trainings for dental providers about care for children under age three, • Training non-dental healthcare providers, such as physicians and nurses, to provide screenings, fluoride varnish applications, education, and referrals to dentists, • Partnering with WIC, Head Start, Migrant and Community Health Centers, Iowa's hospital health systems and other programs, and • Purchasing portable dental equipment for on-site use in facilities such as Head Start. ■ Provide funding to local Title V Child Health (CH) agencies to increase dental program infrastructure ■ Cost: **$1,279,430** (See Appendix *I*) ■ Increase funding to strengthen the state Title V CH database system for tracking patient care coordination and appointments ■ Cost: **$210,000** (*See Appendix IV*) ■ Fund public oral health education and promotions ■ Cost: **$1,044,855** (*See Appendix III*) ■ Fund training programs and create mandatory continuing education requirements for dental and other healthcare providers regarding children's oral health ■ Cost: **$120,000** (*See Appendix III*)
Improve the Dental Medicaid Program	Dentist participation in Medicaid is limited, impacting access to dental services for Medicaid-enrolled children. Strategies to improve the dental Medicaid program include: • Creating a network of dentists willing to see Medicaid-enrolled children through use of a familiar dental insurance carrier with increased reimbursement rates • Reimbursing non-dental providers for providing screening and fluoride varnish to children in settings beyond a dental office, and • Reinstating periodontal (gum) treatment coverage for adults, especially pregnant women and new mothers, whose oral health can affect the oral health of their child

	through transmission of oral bacteria. ■ Contract with a familiar dental insurance carrier to improve dentist participation in Medicaid, similar to a successful program in Michigan ■ Cost: Delta Dental/hawk-i equivalent network: **$28.8 million** (*See Appendix IV*) ■ Create a dental screening code and specific reimbursement for physicians ■ Cost: **$ 3,529,230** (*See Appendix IV*) **includes current annual Medicaid EPSDT exam oral screening and physician fluoride varnish payments* ■ Allow reimbursement for oral screening and fluoride application by non-dental providers ■ Cost: **$0** – Medicaid Administrative Rules Change (*See Appendix III*) ■ Reinstate coverage of periodontal services to adult dental Medicaid enrollees ■ Cost: **$276,000** (*See Appendix IV*)
Implement Recruitment and Retention Strategies for Underserved Areas	The shortage of dental providers in 79 Iowa counties decreases the ability of Medicaid-enrolled children to receive dental services. The strategy is to increase the number of dentists and hygienists in underserved counties include creating loan repayment options for dental and dental hygiene program graduates that practice in rural and dental workforce shortage areas. ■ Create a dentist/dental hygienist student-loan repayment program to increase the dental workforce in shortage areas ■ Cost: **$250,000** (*See Appendix V*)
Integrate Dental Services Into Rural and Critical Access Hospitals	Dental services in rural and underserved areas can be bolstered through the use of rural hospitals, especially for care by pediatric dentists in an operating room for severe early childhood caries (baby bottle tooth decay). The strategy is to use rural hospitals in Iowa's health network systems to increase dental clinic capacity and the availability of primary care services to rural underserved communities ■ Work with rural hospitals to develop dental clinics ■ Cost: **$0**-No cost to the state. (*See Appendix V*)

I-SMILE: ANTICIPATED OUTCOMES

- An integrated dental service delivery system that delivers adequate early identification of disease risk, prevention and dental care
- An oral health care coordination network that assures Medicaid-enrolled children receive appropriate oral health care services
- A guaranteed dental provider network that assures an appropriate level of dental care access for Medicaid enrolled children
- A tracking and monitoring system to regulate outcomes and quality of care within the dental home system
- Intensive family-based oral health education to strengthen parental oversight of children's home care and increase prevention opportunities
- Sufficient oral health education opportunities for health care providers to ensure adequate knowledge to meet the oral health needs of young children
- Recruitment and retention of an adequate number of new dentists and dental hygienists in underserved rural communities
- A decrease in overall dental disease rates among participating Medicaid-enrolled children with subsequent cost savings for the state

To allow sufficient continuity in the I-Smile dental home program and to observe impact on cost and disease rates, **a minimum of five years of program implementation and fiscal support is recommended.**

I-Smile: A Dental Home For Medicaid-Enrolled Children

BACKGROUND

On May 12, 2005, Governor Vilsack signed HF841 into law, establishing the IowaCare Act. The bill includes the following language:

> *DENTAL HOME FOR CHILDREN. By July 1, 2008, every recipient of medical assistance who is a child twelve years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive care identified in the oral health standards under the early and periodic screening, diagnostic, and treatment program.*

The Iowa Department of Human Services is charged with developing a plan to meet the intent of this legislation. This I-Smile Dental Home Proposal is the result of collaborative discussions between representatives of the Iowa Department of Human Services, the Iowa Department of Public Health, the University of Iowa College of Dentistry and Public Policy Center, the Iowa Dental Association, Delta Dental Plan of Iowa, the Iowa Dental Hygienists' Association, the University of Iowa Child Health Specialty Clinics, and other interested parties. The I-Smile Dental Home Proposal provides a comprehensive approach to providing a dental home for all children in Medicaid ages 0-12.

RATIONALE

- Less than 45 percent of all children enrolled in Medicaid have a dental visit during a year[1].
- Low-income children are most at-risk for severe and untreated decay.[2]
- Treatment of severe decay for children ages birth to three often requires hospitalization and costs can range from $2,000-$5,000.[3]
- Tooth decay can be prevented; prevention must begin at an early age.
- Early access to preventive dental services for children has shown significant cost savings compared to delayed access in later years.[4]
- In SFY 2005, there were 164,965 children six months through 12 years of age enrolled in Iowa Medicaid.[5]
- Of these, just 55,825 (34 percent) received a dental examination from a dentist.[6]
- In SFY 2005, 1,464 Medicaid-enrolled children were hospitalized or received general anesthesia for advanced dental treatment. Over 528 of these children were between the ages of one and three.[7]
- In SFY 2005, the total Medicaid expenditures for all dental services provided to children age 12 and under were $13,799,863.[8]
- Of that amount, only $1,147,176 (8 percent) was for preventive screenings, fluoride varnish and/or sealants provided through local maternal and child health agencies and/or physicians.[9]

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[1] CMS 4.16 report
[2] http://www.cdc.gov/OralHealth/factsheets/dental_caries.htm (Accessed February, 2006)
[3] Iowa Medicaid Enterprise dental hospitalization cost report 2005
[4] Savage, Matthew F. et al. "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs." PEDIATRICS Vol. 114 No.4 October 2004, pp.e418-e423
[5] Iowa Department of Human Services
[6] Iowa Department of Human Services
[7] Iowa Department of Human Services
[8] Iowa Department of Human Services

- Once very young children have severe decay, they often require more expensive treatment – often in a hospital. These children are likely to be seen in a medical office or public health clinic before being seen in a dental office, indicating the need to educate non-dental healthcare workers about preventive dental care.

THE DENTAL HOME

The ultimate goal of creating a dental home for all Medicaid-enrolled children, 0-12 years old, is to ensure they receive age-appropriate comprehensive dental care. The American Academy of Pediatric Dentistry's (AAPD) definition of a Dental Home[10] is the conceptual framework for the I-Smile Dental Home Proposal.

According to the AAPD, "The dental home is inclusive of all aspects of oral health that result from the interaction of the patient, parents, non-dental professionals and dental professionals. Establishment of the dental home is initiated by the identification and interaction of these individuals, resulting in a heightened awareness of all issues impacting the patient's oral health."

The AAPD further states that "Children who have a dental home are more likely to receive appropriate preventive and routine oral health care. Referral by the primary care physician or health provider has been recommended, based on risk assessment, as early as six months of age, six months after the first tooth erupts, and no later than 12 months of age. Furthermore, subsequent periodicity of reappointment is based upon risk assessment."

A dental home provides:
- Acute care and preventive services
- Assessment of oral diseases
- Individualized preventive care based on risk assessment
- Anticipatory guidance about growth and development
- A plan for dental trauma
- Information about proper care of teeth and gums
- Dietary counseling
- Referrals to dental specialists

Age-appropriate care has been specified in a reference manual from the AAPD titled "Clinical Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance and Oral Treatment of Children." [11]

CURRENT OBSTACLES

While it would be ideal for all children, especially Medicaid-enrolled children, to see a dentist by age one, there are many reasons why this goal is difficult, if not impossible, to attain. Some of the reasons are related to the overall dental delivery system in Iowa and others are specific to perceived problems with the Medicaid program.

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[9] Iowa Department of Human Services
[10] http://www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf
[11] http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

- There is a shortage of dentists in many parts of the state. According to the Iowa Department of Public Health, 72 of Iowa's 99 counties were designated as Dental Health Profession Shortage Areas (DHPSAs) in year 2001. Current estimates now raise this to 79 counties.

- Many dental practices are very busy - working at capacity - and are unable to accept *any* new patients. This is due in part to both the overall shortage of dentists and the influx of new procedures into dentistry (e.g. cosmetic).

- Many dentists are uncomfortable or unwilling to see children younger than three years of age. Procedures for very young children are different and can be more difficult to complete than for older patients.

- Many dental offices do not accept Medicaid-enrolled children. The low reimbursement for services, administrative difficulties, and poor patient compliance are often cited by dentists as reasons for not participating in the Medicaid program.

- Elimination of coverage for some dental procedures for Medicaid-enrolled adults affects parents', particularly mothers', ability to keep children's mouths healthy. Poor pregnancy outcomes and transmission of decay-causing bacteria are linked to mothers with poor oral health.