Dental Home Proposal for Children in the Iowa Medicaid Program

University of Iowa, Public Policy Center

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Background

Legislation passed in May 2005 establishing the Iowa Care program also included a provision stated that by July 1, 2008 all children in the Medicaid program "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 EPSDT program." Language to implement this proposal has been included in the proposed Affordable Health Care for Small Businesses and Families Bill (LSB 1043XS 8.3). Establishing a dental home for children in Medicaid was deemed necessary because of the unmet need these children have and the difficulty they can have trying to receive dental care.

Components of the Dental Home Proposal

The bill includes the following provisions:

1. Insurance carve out-contracting with private insurance company or dental health plan to cover dental care similar to dental coverage in ***hawk-i*** ($9.9M in state funds, $26M total)
2. Loan repayment program for dentists and hygienists to go to underserved areas of the state in coordination with the economic development activities of the local communities ($275,000)
3. Establishing a dental hygienist as a lead oral health coordinator at all Maternal and Child Health Clinics, WIC clinics, Head Start Centers, local boards of health and schools ($?)
4. Reinstating coverage for periodontal services for adults ($276,000)
5. Portable dental equipment for non-traditional settings ($3.1M to DHS)
6. Enhanced ability to track children's dental health information ($210,000 to DHS)
7. Increased family education on children's oral health through AEAs ($1M to DHS)
8. Increased provider education on children's oral health ($120,000 to DHS)
9. Exams and fluoride treatment by non-dental providers ($?)
10. Supporting families through WIC, Head Start and other community providers ($?)
11. Partnering with rural hospitals to provide dental care in underserved areas ($?)

Dental insurance carve-out

A demonstration in Michigan showed that by employing a private insurance carrier that pays closer to regular dentist's charges, utilization of dental services can be improved. Iowa currently uses this model with the ***hawk-i*** program where Delta Dental and Wellmark are the dental insurance carriers. A study comparing the Iowa Medicaid and ***hawk-i*** programs between 2001 and 2003 found that utilization rates for children after their first year in the program was higher for children in the Wellmark ***hawk-i*** plan (49%) than children in Medicaid (42%) (*http://ppc.uiowa.edu/health/dentalcare/index.htm)*. These studies were done prior to the time that Delta Dental became a ***hawk-i*** participating health plan. Expanding the provider network for children in Medicaid is essential if other goals, such as having every child receive an exam prior to entering school, is to become a possibility.

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Loan repayment program

Iowa has a dental workforce problem with 72 of the 99 counties designated as dental professional shortage areas. The dentist workforce is also getting older with dentists retiring faster than they are being replaced. Dental hygienists are also in short supply in many areas of the state. Health professions shortages hurt the economic viability of communities and their ability to recruit and retain businesses. The proposed loan repayment program would provide an incentive for new dental and dental hygiene graduates to go to underserved areas of the state. Many dental students have over $100,000 in debt at the time of graduation. In coordination with a new Delta Dental sponsored program at the University of Iowa College of Dentistry for helping communities recruit dental students, this loan repayment program could improve access to care in many underserved communities.

Dental hygienists as oral health coordinators in public health clinics

Some children in Iowa have severe early childhood caries (baby-bottle tooth decay), where many of their teeth become badly decayed and often have to receive care in a hospital operating room under anesthesia. This is very expensive ($2,000-$5,000 per child) and almost entirely preventable. This usually begins prior to age three when the child is least likely to have their first dental visit. However these children are often being seen in maternal and child health centers, WIC clinics, Head Start Centers and physician offices. Having a dental hygienist associated with the public health clinics will allow an oral health professional to help with screenings, providision of preventive services (e.g., fluoride varnishes), and the training and coordination of care between non-dental providers and dentists willing to see these young children at risk.

Additional dental care legislative considerations for 2007

1. A different proposed bill would require that all children receive a dental screening prior to starting elementary and high school. This would reinstate the dental card program that used to be more common in Iowa where children had to bring a card to school that was signed by the dentist indicating that all needed care was provided. A primary consideration for this bill, however, is:
   - Should this requirement be for a screening or exam? Exams would better connect the child with treatment at the same time as the needs were assessed, but it is easier to get non-dentists in the locations where at risk children are likely to be.
2. Coverage of root canal for adults should also be considered for reinstitution along with periodontal care. There are no other service areas or diseases for which the Medicaid program excludes coverage in this manner.

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