# Missouri Coalition for Oral Health Access:

# Community Information Gathering
# and
# Coalition Work Plan Through December 2001

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**and**
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## Purpose

The purpose of this report is to present:

- A summary of background research and efforts in Missouri to define the oral health problem, and to improve oral health and access to dental services particularly for the underserved. This summary will include data and information from previous studies, and information collected from seven community meetings sponsored by the Coalition in November 2000.
- The work plan for the Missouri Coalition for Oral Health Access through 2001. The plan was developed at a Coalition meeting on December 12, 2000 in Jefferson City.

## Background: Scope of the Problem

*"Oral health is essential to the general health and well being of all Americans and can be achieved by all Americans. However, not all Americans are achieving the same degree of oral health."*

Oral Health in America, Report of the Surgeon General, 2000

The landmark Surgeon General's report on oral health in America advanced both needs and opportunities to enhance oral health. Two prominent ideas are featured in that report:

- "**Access** to care can make a difference. A complex set of factors underlies access to dental care and includes the need to have an informed public and policy makers, integrated and culturally competent programs, and resources to pay and reimburse for care. The availability of insurance increases access to care."

- "**Federal and state assistance programs** for selected oral health services exist; however, the scope of services is severely limited, and their reimbursement for oral health services is low compared to the usual fee for care."

These two "needs and opportunities" stand out most sharply when providers and consumers are listened to at the state and community level. These opportunities are the foundation of initial strategies proposed by the Missouri Coalition for Oral Health Access. For example, given Missouri's recent expansion of the Medicaid/MC+ program to include persons with incomes up to 300% of the Federal Poverty Level, the demand of this population far exceeds the capacity of dentists currently participating in the program as providers. Insurance in Missouri does not guarantee access, but may make it more probable.

**This background section summarizes information available on access to dental health services for the underserved in Missouri, as well as on the federal, state and local assistance programs available for the underserved.**

The **Missouri Medicaid dental program** was evaluated in 1998 for the purpose of providing recommendations for program improvement. Three different aspects of the Missouri Medicaid program were considered: its fee-for-service ("straight Medicaid") program, the MC+ (Missouri's Medicaid managed care program, recently expanded to include children in families with incomes below 300% of the Federal Poverty Level), and the unique delivery system of the Mid- Missouri system, which both pays for and provides dental care for Medicaid insured persons.

Surveys of dentists and Medicaid recipients in this evaluation led to the following conclusions:

- A limited number of dentists accept new Medicaid insured persons in their practices.
- Dentists' experience is that it is difficult to provide care to Medicaid insured persons.
- Low fees, complicated paperwork, a higher percentage of broken appointments and lack of specialty referral options deterred dentists participation in the Medicaid insurance program.
- Medicaid insured persons cannot find a dentist who will treat them or their children, and while generally satisfied with the quality of care if they did receive treatment, great travel distances and a long waiting time for an appointment were usually involved.

The evaluation also included consumer and provider/dentist focus groups. Table 1 summarizes the observations from these groups.

**Table 1**

| Consumers (Medicaid enrolled persons and knowledgeable professionals) | Dentists |
|---|---|
| *Finding a dentist*: problematic statewide, especially in rural and smaller metro areas<br>*Waiting for an appointment*: if in pain or an emergency, usually hours or days; routine care, 3 weeks – 6 months<br>*Transportation* – universally lacking and problematic, particularly to see specialists<br>*Respect* – generally favorable, but for "unreliable, second class citizens"<br>*Quality* – very satisfactory, with mutual frustration with providers over what is not covered | *Treating Medicaid patients* – break appointments, show up late, make after hours calls, less informed, less interest, don't follow up on care, poor role models for children, and don't value oral care.<br>*Oral health issues* – more serious oral health problems than other patients, seek care more often for pain, more baby bottle tooth decay<br>*Reimbursement* – "most severe denunciations" and reason for lack of participation in the Medicaid program |

| | |
|---|---|
| | *Medicaid claims administration* – compared poorly with that of commercial insurers<br>*Quality* – inhibited by limited coverage of the Medicaid program<br>*Patient needs* – Medicaid is a fraudulent entitlement because the providers are not available to treat the population |

Following the evaluation, there have been significant, but potentially "unfelt" **changes to the Missouri Medicaid program**.

**Missouri Medicaid Program Changes**

- There has been an increase in appropriations for dental services for three years in a row. The Division's goal is to achieve funding for reimbursement at 75% UCR of the 1999 ADA fee schedule by SFY 2003.
- Coverage of services for adults has broadened, so that there are fewer procedures covered only for children.
- Clinics, such as local health departments, may now enroll as dental providers.
- The Medicaid dental manual is now available on the Internet at www.dss.state.mo.us/dms
- Dentists may report broken appointments to DMS, using code "DNKAS" or "did not keep appointment as scheduled." While there is no reimbursement for broken appointments, the division uses this information to follow up with the families to provide counseling on the importance of keeping all scheduled appointments and to explore whether lack of transportation is the problem.
- Prior authorization is no longer required for the initial placement of full dentures and partial dentures.
- Claims filing has been made even easier:
    - The department accepts the new 2000 ADA claim form
    - The departments system automatically inserts the first digit of the procedure code so that old ADA codes can be accepted, as well as new "D" codes
    - The requirement to add modifiers to procedure codes has been removed
    - The department adjudicates electronic claims on a nightly basis, which allows billing offices to more expeditiously be informed about and fix billing problems.
    - A variety of other improvements that have resulted in faster claims processing, with fewer denied claims. Nearly 95% of dental claims are processed within 15 days.

The Department of Social Services also developed in November 2000 the document **"Dental Dilemmas Facing Our State."** This document summarizes data on the dental workforce for the state of Missouri and data on the Missouri Medicaid dental program. The Missouri Department of Social Services' effort to address challenges through increased appropriations for dental services and dental care, as well as some of the administrative streamlining and policy changes listed under the "Program Changes" above are also included in the "Dental Dilemmas" report.

The **Citizens for Missouri's Children issued a report in January 2000**, specific to children insured by Medicaid or enrolled in MC+ in the St. Louis region. The following parameters defined the "crisis in access" for these children:

- Low reimbursement rates for dental care by Medicaid
- Shortage of dental professionals
- Low provider participation in MC+/Medicaid
- Administrative burdens associated with the Medicaid program
- Broken appointments

- Problems in assembling adequate networks through managed care plans
- Lack of Early Prevention, Screening, Diagnosis and Treatment (EPSDT) compliance – which is a provision for comprehensive prevention for Medicaid enrollees under age 21
- Public Health and Dental Education is lacking (evident in baby bottle tooth decay, lack of water fluoridation and the lack of research and evaluation)

The **Missouri Head Start Collaboration** indicated in 1999 that just under 1/3 (27%) of Head Start Children could not receive a dental exam in 90 days. Roughly the same percent of Head Start Children do not receive ongoing, routine care. Most Head Start children are also eligible for or enrolled in Medicaid/MC+; the challenges to access already listed for this program are their barriers as well.

There are **resources and programs** in Missouri that provide dental services to the Medicaid/MC+ insured or uninsured. A partial list of those resources is shown below in Table 2.

**Table 2**
**Resources and Programs for the Underserved in Missouri**

- There are volunteer clinics, where care is usually free or low cost:
  - Free Primary Clinics
  - Free dental clinic (Kansas City)
  - Kings Daughters in Boone County provides care for uninsured children
- Several federally funded community health centers across the state have dentists on staff or are developing a dental service component.
- Communities across the state are developing their own solution to the demand for emergency or urgent dental services, as well as routine care for populations typically underserved:
  - Marion County has a volunteer dental clinic at the Health Department. Dentists secured new equipment, volunteer their services, provide dental assistants, and bill through the Health Department. 60% of children in Marion County are on Medicaid or MC+.
  - Randolph County has a primary care clinic in the health department, which also has a dental program. Children were scheduled for services at dental clinics through the Health Department; 12-24 children were served at each clinic. The United Way provides $20,000 per year for services, including "coupons" which are good for a referral to a local dentist. A dental hygienist has been hired to help the dentist who provides services, as well as to provide education out in the community.
  - A clinic has been established at the Springfield/Greene County Health Department, which is allowing providers to serve Medicaid patients. The clinic has its own Medicaid billing ID number. The waiting list is already through March 2001.
  - The Miles for Smiles grant, which provides dental care to Medicaid insured children, serves seven southwest counties, including Greene County. Some volunteers have been used in this program.

- Boone County has an adult dental pain relief clinic, funded by the United Way and the County, and administered by the local community health center and health department. Participating dentists have agreed to accept a standardized, discounted fee schedule. The up front co-payment for this service is often refunded to clients due to the inability to find dentists who will perform the extractions that the patients require.
- Platte and Clay Counties have begun local efforts to address access problems for their underserved populations.

- University of Missouri, Kansas City (UMKC) is developing outreach programs in St. Joseph's, Nevada, and Theodosia for dental students.
- Area Health Education Center (AHEC) is helping to facilitate the first meeting of free clinics across the state. A conference will be held on April 6th and 7th 2001.
- The United Methodist Church has dedicated 20% of its collections as well as a staff person to work with communities across the state to improve access to dental care.
- The Elks Dental Van provides dental care for the developmentally disabled

The Missouri Coalition for Oral Health Access identified the following resources, also in January 2000:

- The Department of Health requested funding to facilitate placing 20-30 new dentists over two to three years in identified high need areas to provide access to care for the uninsured and low income, as well as Medicaid insured populations.

- The Department of Health, Bureau of Dental Health, the UMKC School of Dentistry and the Department of Economic Development are preparing data for policy makers on the supply and demand for dentists and dental hygienists.

- The Department of Health, through the Primary Care Office and the Bureau of Dental Health funded approximately 10 sites across the state in SFY 2000 to expand or initiate dental services at community health centers and/or local public health agencies.

## Community Discussions Sponsored by the Missouri Coalition for Oral Health Access, November 2000

The Missouri Coalition for Oral Health Access hosted a series of meetings in Maryville, St. Louis, Kirksville, Poplar Bluff, Columbia, Springfield, and Kansas City in November 2000. The purpose of the meetings was to gather advice for the Coalition and its Work Groups, as the basis for developing the Coalition's next steps. The Coalition was also seeking to educate communities about efforts to improve access to dental care and oral health services.

An initial set of strategies to address challenges in Missouri were developed by the Coalition in February 2000 (listed in Table 3).

**Table 3**
**Initial Strategies Proposed by Missouri Coalition for Oral Health Access**

- Aggressive education campaigns that assist private dental professionals to integrate Medicaid patients into their practices, particularly by informing dental professionals about favorable changes in the Medicaid program.
- Expanding and enhancing the ability of community health centers to provide quality prevention and dental health services to the Medicaid insured and uninsured population.
- Implementing approaches – including financial incentives -- that will attract more dental health professionals to the state, particularly underserved areas.
- Pilot projects that can help to demonstrate how improved patient education can encourage compliance with appointments and dental care.

Findings from the November 2000 community meetings around the state support the need for these strategies:

- **Access to dental care is a persistent challenge** for the elderly, the disabled, low income uninsured and Medicaid insured adults, Medicaid insured and uninsured children, especially those insured by the fee-for-service program. There are few dentists in any community accepting new Medicaid patients, both because of the low reimbursement and the potential to be overwhelmed with the demand once they accept patients with Medicaid insurance.

- **Changes to the Medicaid program** have made it a far more responsive and streamlined insurance product. Knowledge of these changes, and recent positive experiences with the program need to be more widely known. Dentists, advocates and others are often operating from negative experiences with the Medicaid program from the past. There is also a significant amount of "bridge building" that needs to occur between the Medicaid program and dentists, as well as the advocacy community.

- **Community health centers** – while a resource for dental care for low income uninsured and Medicaid insured persons -- face dual challenges:

1) the same volume and treatment pressures and challenges experienced by private practices are experienced by dentists working in community health centers; 2) the operation, financial and regulatory requirements for and reimbursement to community health centers are not understood by the private dental community.

- There is a **lack of clarity and understanding** on the part of private dentists as well as other community members about the role of government, or federal/state government assistance in providing and paying for dental services, or in supporting community health centers that have dental programs.

- The **capacity of the current dental workforce** to meet demand is a concern across the state. There is concerted work being done by the Bi-State Task Force at UMKC to look at issues of recruitment and retention. Community members, and staff or leaders of health and social service programs generally believe that there is a shortage of both dentists and hygienists in Missouri. There is not, however, a clear statement from either dentists or dental hygienists as *professionals* if there is a shortage of either in the state. The common ground for all is the recognition that there is a mal-distribution of these professionals in the state, with fewer providers in rural areas.

- There are strategies from other states and communities in Missouri that are working to help individuals, families and providers to **improve access through education of patients**. These strategies are usually combined with intensive case management and infrastructure that supports access (such as transportation). Examples and good suggestions for teaching the value of dental care and oral health were shared during the community meetings, such as the Nebraska "Medicaid school."

Additional observations from the meetings in November 2000 included the following:

- Strategies and attention have been focused on Medicaid and MC+ -- **comparatively little has been focused directly on the uninsured** and their access to dental services. However, changes in the Medicaid program or other strategies that funnel more resources to the infrastructure of dental health providers in the state directly relate to providers ability to continue seeing completely uninsured patients.

- The **no-show rate for dental appointments** for the Medicaid insured is cited as high across the state (30-50%) and as one of the primary reason

that dentists will not participate in the program. No-show rates for privately or commercially insured person, or the uninsured are generally not known or not tracked.

- Dentists cite **negative perceptions or experiences with federal programs**; however, most had some kind of federal or state funding or loan repayment assistance for their education (e.g., I.H.S. or loans).

- **Expectations for programs funded with public dollars** (Head Start, Medicaid) that are not necessarily part of private sector programs. The inability to meet these expectations and requirements is often how problems or challenges with access to dental care are identified. Providers who have to work with both face challenges in developing a streamlined operation for the varying requirements.

- There is a **shortage of dentists participating in the Medicaid/MC+ program across the state.** The additional expansion of eligibility for Medicaid/MC+ in Missouri over the past year has increased the number of persons with insurance coverage through these programs and exacerbated the challenges that eligible persons have in finding an available dentist.

- The increased "volume" of persons eligible for Medicaid/MC+ in Missouri has **increased the demand for services from dental specialists, especially those who serve children.** Managed care plans, as well as the Medicaid program, struggle to assemble an adequate network of dental specialists.

- Dentists in the community meetings stressed that encouraging and securing **volunteer dentists** to provide services in a separate clinical setting is typically a model that will work at the community level to reach more underserved persons, rather than incorporating Medicaid insured and the uninsured into existing dental practices.

- **UMKC – as the only dental school in the state – is experiencing significant pressure** to maintain or even increase the supply of dentists in the state. The Bi-State Task Force is looking at issues and approaches to developing and retaining dental professionals in Missouri.
  - Budget changes have led to an increase in research dollars and the perception that the school is more interested in research than direct care.
  - Some slots for dental students are committed to other states and countries; these commitments have spanned many years.

- Lack of access over time has created a **backlog** of dental and oral health needs that surface as emergencies. Participants in the discussions generally agreed that any direct service programs established in the state or a community provide crisis care and treatment in the short term because of this backlog.

## Missouri Coalition for Oral Health Access: Work Plan for 2001

Participants in the community meetings across the state acknowledged that there is not one single strategy that will improve dental and oral health in Missouri. **Multiple strategies, in multiple locations, at the state and local level, must be implemented simultaneously for there to be a measurable change in the experience of the underserved and uninsured persons access to dental services, and in their overall oral health.**

This section of the report outlines the purpose, desired outcomes, structure, and proposed strategies of the Missouri Coalition for Oral Health Access through December 2001. These strategies were decided at a planning meeting on December 12, 2000 in Jefferson City and drew on the advice received by the Coalition in the November community meetings. At this planning session, the Coalition recognized that it is building infrastructure and a process to sustain activities into the future, in addition to achieving short-term change.

### Purpose of the Coalition

The purpose of the Coalition advanced at the December 2000 session for the Missouri Coalition for Oral Health Access is to:

- Develop a statewide oral health initiative, which produces a Missouri relevant state oral health plan, based on Healthy People 2010 and the Surgeon General's Report on Oral Health
- Plan and implement strategies that improve access to oral health (including prevention, wellness, addressing fear)
- Serve as the unified voice for the majority of the stakeholders in this issue
- Focus on the entire population, with a special focus on the underserved and uninsured
- Address disparities in oral health status and access to dental services across Missouri
- Promote progress, hope and change for the future

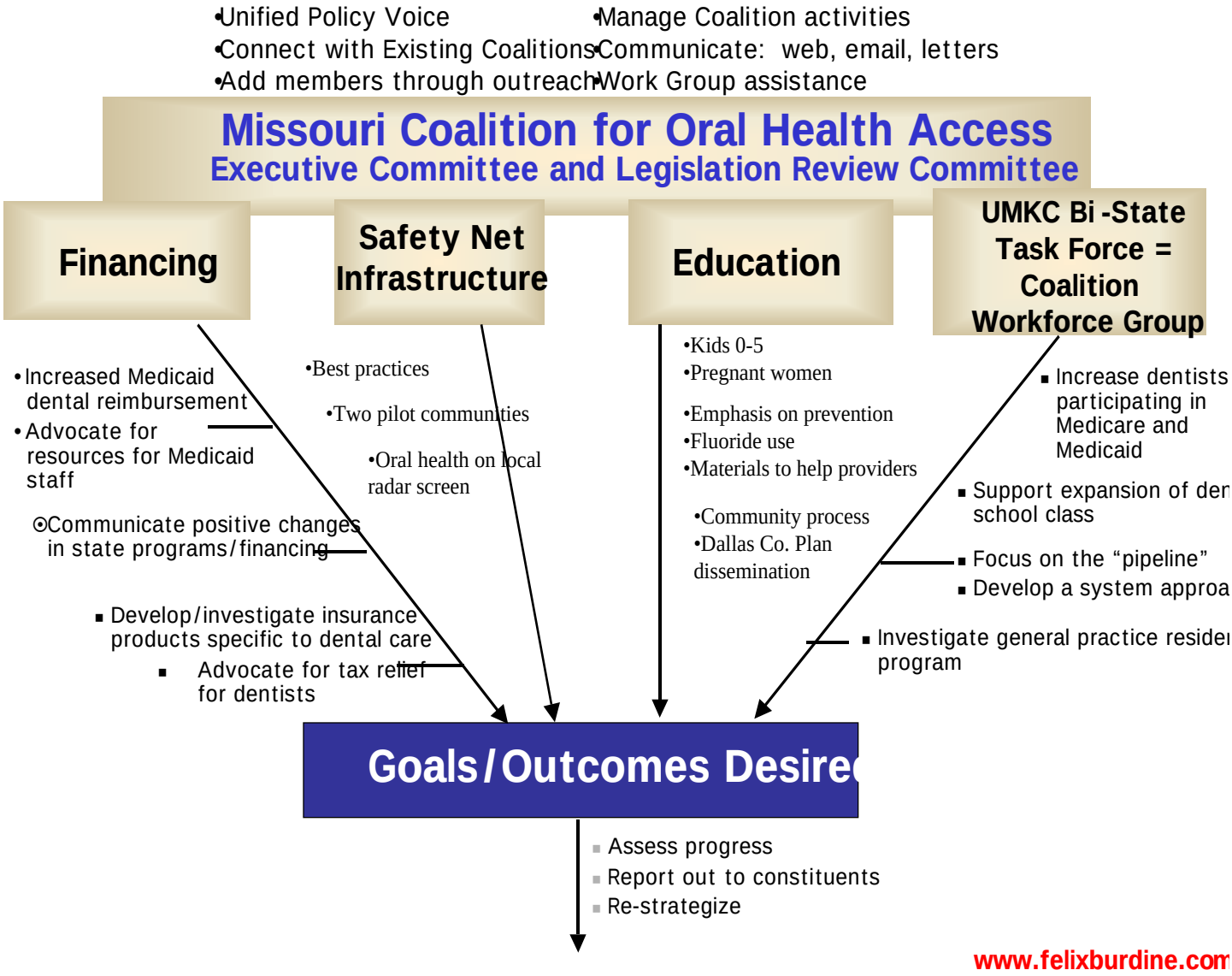
### Outcomes Desired by December 2001

The Coalition would like to achieve or see the following outcomes by December 2001:

- A state oral health initiative plan is drafted, and several initiatives in that plan would be funded or supported.
- An increase the number of dentists accepting Medicaid patients.

- A functioning dental program would be in place in all fifteen (15) federally qualified health centers in Missouri (ten centers currently have a dental program).
- An increase the number/extent of public education programs on oral health.
- An increase the number of people/organizations participating on the Coalition by at least five (5).
- A process is securely in place to identify, organize and share the activities happening around oral health education/promotion in Missouri among the Coalition Work Groups
- The Coalition will work to support passage of Senators Sims Bill (47)
- The Coalition will support the appropriations suggested for the budget by the Department of Social Services, which would secure another $7.03 million for dental services through Medicaid for 2001.
- The Coalition would support and enhance oral health education/promotion efforts occurring in the schools by working with the Department of Education.
- There will be accurate and current lists of dentists accepting Medicaid patients, organized at the regional or community level, and housed in a central location (like a community health department). This will be done in a process that is acceptable to dentists in communities.
- The Coalition will identify best practices, decide what needs to be done to promote/replicate these, and determine the best ways to share information about best practices across the Coalition.
- Ultimately, there will be fewer people in pain because of the Coalition's efforts.

## General Coalition Structure



**Coalition Executive Committee**

The structure and function of the Coalition were decided at the planning meeting:

*General Structure and Processes*

- A coalition executive committee was established. This committee will include the chairperson of each work group, the Coalition chair and staff (currently from the Missouri Primary Care Association), and other key stakeholders, such as the Missouri Department of Health, Bureau of Dental Health, the Division of Medical Services, Department of Social Services and the Division of Family Services.
- The Coalition Executive Committee and Work Groups will strive for consensus in decision-making. Where there is not consensus, groups or the Executive Committee will vote, and the majority will rule.
- Each year in November, the Coalition will meet to review progress, and determine priorities for the upcoming year. The Executive Committee will meet in early December to review the results of the planning meeting.
- The Coalition will need "staffing" help from the Missouri Primary Care Association, as well as other organizations that might have time or resources to devote to the Coalition. Attendance at work group and Coalition meetings, helping to circulate communications, assisting chairs to schedule meetings and distribute notes are some tasks that will require staff persons.
- The Coalition must establish a central place for communication and information sharing. A website was the recommended vehicle. One model for the Coalition to replicate for organizing information and Coalition activities is the website for the Colorado Coalition for the Medically Underserved *(www.ccmu.org*).

*Legislative Function*

- The Executive Committee will serve the following legislative/policy functions for the Coalition:
    - Circulate a comprehensive list of proposals and budget allocations/appropriations *directly related to oral health and dental access* for each year and legislative session. Oral health and health care lobbyists from several stakeholder groups will be convened to help organize this list each year. Legislative staff analysis of bills would be helpful to examine in this process.
    - The Executive Committee will draft a position statement for the Coalition on each proposed bill or allocation. This position statement will indicate support for bills (and the concepts they represent). Where there is not consensus on support, the

*concepts* that are supported by the Coalition with an explanation of differences among constituents.

- The Executive Committee will communicate via email and conference call to finalize position statements and support for legislation, and allocations.
- The Coalition's position statement should be sent annually in a letter to legislators, State House and Senate leadership, as well as the Governor's office.
- The Coalition will meet in January of each year to discuss and determine legislative priorities for the session based. A legislative briefing could be held in Jefferson City each year, as part of the Coalition's annual progress report to policy makers.
- Legislative needs or ideas from each work group will be represented or brought forward by the Work Group chair, which is on the Executive Committee.

· The Executive Committee of the Coalition will determine support for bills in the future by circulating information to each work group through its Chair, who will then obtain consensus from the group and/or inform the Coalition Chair of any disagreement or discussion. The Executive Committee can resolve or address conflicts.

*Measures of success for the next year around the legislative function include:*

· An established and up to date list of pending or proposed legislation that is relevant for oral health in Missouri.
· A functioning process for distributing information about upcoming legislation to the entire Coalition.

**Coalition Work Group Strategies through 2001**

A list of possible strategies for each Coalition work group was brought to the planning meeting on December 12, 2000. These strategies were a combination of ideas already in progress, as well as a list of strategies advised by community members during the November meetings *(Note: the full list of strategies advised during the November meetings is included in the Appendix to this report).* The direction for each work group through December 2001 is illustrated below and described in detail on the following pages.

<u>Education Work Group (Chair: Chris Groccia, Missouri Head Start Collaboration)</u>

The Education Work Group has already identified target groups and messages of importance for their first year of work.

*First*, pregnant women and children age birth to five are the target groups of interest. The work group has placed emphasis on educating every group that comes into contact with pregnant women and young children – preschool and kindergarten teachers, childcare providers, and other constituents. *Second*, absent universal public water source fluoridation, the group decided to focus on the education of these target groups about the benefits of fluoride and the best practices for increasing fluoride use: promoting fluoride varnishes, promoting brushing in schools. This second aspect is grounded in the work groups' desire to focus on prevention and providing prevention information and support to those persons who work with or come into contact with children.

Additional strategies for 2001 that this group will adopt include the following:

- Dallas County has developed a program for community wide oral health education and health promotion; the education work group could distribute and promote the Dallas County model to other communities.
- The Education Work Group could help develop the *process or system* at the community level for distributing information on oral health to the multiple constituencies who come into contact with families and young children, the best models for information and education available on the topics of interest, and the best way to make use of the information that is available.
- This work group was also asked to take on the strategy of educating people about federally funded community health centers: what they are, how they are funded, and how they work to improve access to dental services. This would include sharing with private dentists and communities the profile and demographics of patients seen at community health centers.

*Measures of success for the next year include:*

- Evidence that products/materials about the benefits of fluoride and oral health are in the hands of people who work with children age 0-5.
- A write up of the "process" for distributing and disseminating information will be available to the Coalition.
- Best practices for promoting use of fluoride for the target audience, particularly where public water sources are not fluoridated, will be posted on a website.
- A count of how many people have heard about/read or implemented a piece of the Dallas County education plan.

Community Safety Net Infrastructure (Chair: Gloria Crull, Executive Director, Family Health Center)

The strategies that will be pursued by this work group over the next year include the following:

- Find, evaluate and disseminate best practices for community-based efforts to refer people for dental care, deliver dental services and recruit providers of dental services. Develop a list or some content that describes these best practices.
- Work with established community coalitions (such as CHART, Healthy Communities, and Caring Communities) to disseminate these best practices and to ensure that oral health is a priority for action.Work with the Missouri Primary Care Association to identify two communities that can serve as a demonstration for the range of strategies proposed by the Coalition, and the eventual "Missouri State Oral Health Plan."

*Measures of success for the next year include:*

- Evidence that content about best practices has been distributed among members of the Coalition.Two communities identified to serve as demonstration areas.
- Oral health component evident in local CHART coalitions.

Financing and Reimbursement (Chair: Jake Lippert, Missouri Dental Association)

The strategies that will be pursued by this work group over the next year include the following:

- Continue support for increased reimbursement for the Medicaid program's dental services; this year the increase will mean that the overhead for serving Medicaid insured patients will be covered.
- Pursue support for a tax credit to dentists who serve the Medicaid insured population.
- Examine proposals that require financing "manpower" in the state that will be required improve dental access and the delivery of services, including dentists as well as staff at state agencies (e.g., Medicaid). Advocate for resources for manpower where fitting and possible.
- Examine current insurance for dental services, both commercial and public plans. Look at the flow and timing of payments, and at the adequacy of what they cover for the insured population. Make recommendations for a dental insurance product for Missouri.

*Measures of success for the next year include:*

- Plan that contains a description of available and adequate insurance coverage for dental services, with recommendations.
- Passage of the Medicaid budget as written.

Workforce, Recruitment and Retention (Chair: Mike McCunniff, University of Missouri, Kansas City (UMKC) Dental School)

- The Coalition decided to have the Bi-State Task Force at UMKC – which is already looking at recruitment and retention issues – serve as this arm for the Coalition. Mike will be responsible for focusing any Missouri-specific activities that need to be addressed.
- Coalition members asked that each type of dental professional be represented in this group's deliberations (including dentists, hygienists, and dental assistants.
- Mike will distribute to each member interested a write up of the strategies and ideas currently being considered by the Bi-State Task Force.

Strategies to be pursued by this group include:

- Investigating rural preceptorship opportunities for dental students.
- Support efforts by the Dental School to increase class size, and to upgrade the facilities needed to appropriately educate and train dental students.
- Increase the participation of current dentists in caring for Medicaid and Medicare insured persons.
- Investigate the possibility of a dental general practice residency program that can provide a source of dentists to rural areas in the state.
- Tie projections about need for workforce to population based utilization standards (e.g., "if each adult should have one preventive visit per year, then we need X number of visits for the state, which can be provided by x number of dentists")
- Advocate for the development of a strong "pipeline" plan – all efforts around recruitment and retention have to be tied to a system approach for increasing the capacity of the state, beginning with very young people in middle school and high school. This effort can be tied to the efforts of the Education Work Group to create a community-based network and process for disseminating information.

*Measures of success for the next year include:*

- Financial support through the legislature for the UMKC dental school to increase class size.
- Increased number of dentists who provide care to the Medicaid and Medicare insured population.
- Statement of projected need for the state based on population based utilization standards.

## Closing

The Missouri Coalition for Oral Health Access will begin work to meet is year 2001 outcomes beginning in January 2001. Members from across the state, from all constituents are needed to reach these goals.

To get involved in the Coalition as a work group member or for more information contact:

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# Appendix

**Strategies Recommended during Community Meetings**

**Notes from Community Meetings**

**Sign up sheets from Community Meetings**

# Strategies for the Coalition and Work Groups: Advice from the Community Meetings, November 2000

### Strategies Advised for the Coalition

- Serve as a unified policy voice for improving dental access and oral health in the state, and as an umbrella for efforts in the state seeking policy, legislative and resource changes.
  - Become ***the*** resource and educated voice for legislators on the oral health issue
  - Advocate for the Medicaid program and their proposed budget increases, as well as for staff resources for the program to remain responsive
  - Advocate for dentists to be part of the PRIMO program
  - Monitor the state's use of Medicaid funds and advocate for funds to be retained or directed to other initiatives if not spent on direct dental care
- Connect with existing state coalitions to secure involvement in the Coalition: Caring Communities, Maternal and Child Health Coalitions, Regional Dental Bureau Program Representatives, CHART communities at the local level
- Consider the development of an "Outreach Committee" that would have the responsibility for securing new members for the Coalition and advancing the Coalition's goals to existing Coalitions.
  - Help develop or find existing, local oral health/dental health coalitions.
  - Find a mechanism to connect people -- develop a website that catalogs or lists the efforts in communities or demonstration programs around the state to improve dental access. Provide contact numbers and program descriptions so people can learn from each other.
- Add members to the Coalition from the following groups: Parents as Teachers, Corrections Facilities/Programs (which have dental resources), health professions schools in addition to dentistry (public health, nursing, medicine), school nurses associations, corporations, insurance companies (?), CHART and Caring Communities.
- Promote National Children's Dental Health Month (February 2001)—take advantage of this by advancing and supporting strategies to increase dental access for children.

**Education**

- Advance public water source fluoridation across the state.
- Educate child care providers about oral health, so they can support good oral health practices in children.
- Highlight pilot/best practice programs across the state.
- Develop and disseminate a one-page summary of oral health issues in Missouri.
- Consider the development of a video that can communicate to policy makers and a broad audience what the critical dental access and oral health issues are in Missouri, and what solutions the Coalition is advocating.
- Support legislative efforts to improve access to oral/dental health services.
- Advance the idea of a "Medicaid school" for both enrollees as well as dentists.
- Find ways to bring the resources of the Missouri Public Health Library to more programs and individuals across the state working to promote oral health and access to dental care. If a website for the Coalition is created, a link to these resources would be helpful.
- Work with school programs that are teaching children to use the Internet and have their topics of interest or content be about oral health and hygiene. Determine if there are ways to influence the content of elementary school curricula to teach oral health through examples.
- Provide oral health information to hospitals or other organizations offering Lamaze classes.

**Recruitment/Retention of the Workforce**

- Coordinate/recommend volunteer strategies, and help investigate barriers to these programs, such as liability for dentists volunteering or providing other services in free clinics.
- Develop a coordinated strategy to connect with medical professionals, especially pediatricians and ob/gyns, and determine how oral health information/education can be provided to children and mothers. This could include convening meetings of these professionals in collaboration with MDA.
- Advance the PRIMO program, and add dentists and dental hygienists to the list of eligible providers.
- Work with existing state and local programs that are trying to recruit dentists to the state to fill the available National Health Service Corps loan repayment positions available. In rural areas, this might mean developing additional incentives to help providers establish a practice, such as assistance with equipment or help in buying a retiring dentists' practice.

- Investigate development of a general dental practice residency program through hospitals across the state.

*NOTE*: the Bi-State Task Force organized by UMKC is addressing many of these issues. MPCA and others are on the Task Force and Mike McCunniff from UMKC will be at the meeting on the 12th, which will help with coordination of ideas.

**Financing**

- Secure increased Medicaid reimbursement or alternative sources of payment for dental procedures.
- Secure resources necessary for Medicaid staff to comply with quality and reimbursement approaches that appeal to private dental practices.
- Support and continue to communicate the changes made in the Missouri Medicaid program to private practices across the state, focusing on office managers as well as dentists.
- Develop insurance products specifically for dentistry that can be purchased by families or individuals who do not currently have this coverage.
- Consider the feasibility of creative financing options: for example, one community discussion recommended that the reimbursement for care of an FQHC patient should be the same at the FQHC or if seen in another practice in the community.
- Investigate the possibility of securing higher Medicaid or other reimbursement for dentists in rural areas, or income tax incentives for dentists, or their practices (as a small business).
- Consider the solutions for improvement in Medicaid delivery already developed by the Medicaid evaluation process include:

| **Consumers (Medicaid enrolled persons and knowledgeable professionals)** | **Dentists** |
|---|---|
| Increase number of providers<br>Expand coverage<br>Improve prevention and education for children<br>Reduce time for an appointment<br>Tax incentives for those who take Medicaid<br>Invest in dental hygiene<br>Encourage better communication between dentists and patients about their frustrations as well as about procedures<br>Improve the emergency system<br>Require all dentists to take some Medicaid patients<br>**Create a salaried state dental corps to treat Medicaid patients**<br>Create an information and referral center to assist in finding a dentist | Use ADA codes and insurance forms<br>Expand service coverage and remove limitations<br>Reimburse dentists for after hours care, no shows and impressions<br>Service requirements and loan forgiveness for UMKC dentists and dental hygienists<br>**Salaried public health dental corps for underserved areas**<br>Use Medicaid dollars to subsidize volunteer efforts at free clinics<br>Encourage parents to be better role models<br>Pay for interpreters for patients who do not speak English |

*underlined strategies are similar between the two groups

+NOTE: It would be important to consider this same benefit for dentists and dental hygienists recruited from other states and other dental schools as well.

**Community based initiatives/Safety Net Infrastructure**

- Determine and promote best practices for community based dental/oral health programs.

- Support/encourage/help to develop networks of dental health professionals, particularly in rural communities.
- Secure resources to fund CHC expansion of dental programs.
- Determine strategies that establish rotations through existing practices that serve poor and minority patients, as well as the disabled; this will increase the number of dentists that are familiar with treating these populations.
- Replicate the Head Start collaboration model for getting dental screenings and potentially ongoing care for very young children.
- Determine the best approach or strategy for educating the general public and private practitioners about the community health center model.

## Notes from Oral Health Community Meetings

The notes from each community meeting sponsored by the Missouri Coalition for Oral Health Access are detailed in this section of the report, in order by meeting date:

| Location | Meeting Date |
|---|---|
| St. Louis | November 14 |
| Maryville | November 14 |
| Kirksville | November 15 |
| Columbia | November 15 |
| Poplar Bluff | November 15 |
| Springfield | November 16 |
| Kansas City | November 16 |

The agenda for each of the community meetings was as follows:

- Welcome and Introductions
- Issues and challenges to accessing dental care or oral health
- Ideas, strategies or groups already in place and working on dental access or oral health
- Advice for the Missouri Coalition for Oral Health Access

A representative from the Missouri Coalition for Oral Health Access was present at each meeting to provide the welcome, and additional background information on the Coalition. Felix, Burdine and Associates served as facilitators for each meeting.

## St. Louis

**Issues**

- Barriers to access include lack of providers accepting Medicaid (both public and private providers) and an inaccurate list of dentists that accept Medicaid patients in their practice.
- Other barriers to care include: fear, lack of comfort with or trust of the dentist, perceptions, language barriers, cultural values, inability of the elderly and disabled to get to points of care.
- The capacity of the state to provide dental care is shrinking, as dental professionals are lost to retirement and not being replaced. This has resulted in an overall decrease in dental manpower in the state.
- There is a story behind the data that is not being told: the number of people seen and the number served (and who need to be served) has to be more effectively communicated.
- Waiting times for dental services can be up to a month or even a year – waiting lists exist everywhere and many practices are closed.
- Lack of transportation, especially in rural areas, is a barrier to accessing dental services.
- The degree and severity of the need is overwhelming; there are many advanced problems that are not taken care of. Access to oral health specialists, particularly for children, is lacking. Referrals are problematic.
- Water fluoridation needs to be more widespread.
- The role of parents in the oral health care of their children must be better emphasized. Parents' education and perception of the value of oral health have an impact on how effectively they pass on good oral hygiene to their children.
- There is no oral health safety net beyond routine dental care. Federally qualified health centers, health departments, and emergency rooms are largely meeting emergencies and providing pain relief.
- Medicaid reimbursement does not adequately cover the cost of services; the process and protocol for reimbursement has been problematic in the past. Additionally, coverage for poor adults is almost non-existent.
- Dentists need to have exposure during academic training to the Medicaid population, as well as the disabled and other special populations.
- There is a lack of knowledge about what is available and how to access existing resources. This leads to duplication and gaps.
- Benefits from welfare expire for those who are returning to work – which creates a barrier to services. There is also a six-month waiting period to enroll in MC+ once dis-enrolled from Medicaid.
- It is difficult to take time from work (especially for hourly employees) and to find child-care in order to make dental appointments.

**Resources**

- Community health centers
- City and county health department
- JFK Clinic at St. John's
- Colleges: Community college, UMKC, EMSU (these all train health and dental health professionals)
- St. Louis Dental Society
- Cardinal Glennon Hospital
- St. Louis University
- Hospitals
- Division of Family Services (DFS)
- Elks Mobile Vans (3 in Missouri)
- Remote Area Volunteer Corps
- Analysis of access for Medicaid/MC+ children done by Citizen's for Missouri's Children

**Advice**

- Oral health networks of providers are needed, to distribute the referral load for regular or charity dental care.
- Promote the Doral Dental model of care, which has case managers, and more personal attention to each person, which increases the success rate for dental appointments.
- Educate and inform policy makers, providers and consumers about oral health status of the population, resources available or lacking, access barriers, policy barriers to better serving the population, and prevention and compliance issues.
- Support local oral health coalitions that can advance the mission of the Missouri Coalition for Oral Health Access ("St. Louis Oral Health Coalition").
- Unify across the state and create a dental health voice that can advocate for resources and strategies (network development, case management, advocacy and outreach).
- Connect with the medical community.
- Provide resources and support so that the Medicaid program can: 1) provide more technical assistance in a personal way (by calling or visiting providers and enrollees), 2) reduce the paperwork, 3) increase resources for direct services, which will allow providers to spend more time with patients.
- Disseminate best oral health practice models (e.g., CT Dental Hygiene Model).
- Advance "home grown" strategies: loan repayment programs; state and federal resources to support the National Health Service Corps; active recruitment of providers by communities by honestly packaging the

challenges and opportunities, as well as the special populations and poverty that is found in rural areas of Missouri.

- Add dental hygienists to the list of providers eligible for the PRIMO program.
- Keep the process and strategies manageable: target population; determine a piece of the problem or a place to start.
- Enhance existing resources, such as the capacity of federally qualified health centers to deliver dental care. This must be coupled with a discussion on the role of community health centers with private dentists in the community.
- Enforce the idea of "dental neglect" among children in the community or state.
- Use established partnerships and forums, such as the Maternal and Child Health Coalition, which could serve as an umbrella into which oral heath can be folded. Coordinate efforts with existing Coalitions to decrease fragmentation and "wheel reinvention."

**Case Studies:**

**Dr. Shirley Pierce, Pediatric Dentist, St. Louis Missouri**

- 80% of Dr. Pierce's practice is Medicaid insured persons; her patient base is composed of children, adults and the developmentally disabled.
- Patients treated through Dr. Pierce's practice require more money, staff, equipment, and training to provide adequate care. Current Missouri Medicaid reimbursement levels do not meet these requirements.
- 35-40 patients a day are provided care through the practice.
- Patients from Missouri, Illinois and even Tennessee come to Dr. Pierce's for care.
- Dr. Pierce will be retiring soon – and her 8,000 patients on file will have few if any options for another dentist.
- Rotations for dental students, to familiarize them with the developmentally disabled population, are needed. Orientation for all dental professionals – including hygienists and assistants – is also a great need.
- A streamlined Medicaid billing process will help providers who are trying to get by on volume with Medicaid reimbursement to continue to do so.

**St. Louis Comprehensive Community Health Centers**

- Challenges to providing comprehensive dental and oral health care:
  - Staff turnover
  - Consistent and constant recruitment efforts for dentists
  - Reimbursement from Medicaid is problematic for private providers
- The center is ready to expand its current dental operation, which has 4 dentists that see 10-15 patients each per day. As of November 14, 2000, the Center was booked until January 2001.

## Maryville

### Issues

- Smaller groups need a Coalition to create a voice in the legislature, to secure financing and resources.
- Parents need to have information about what dental and screening services their children need at an early age.
- Decision on the part of the state to make persons up to 300% of the federal poverty level eligible for MC+ is putting a strain on resources – people might be eligible, but the providers are not there to accept them.
- The paperwork for Medicaid is overwhelming (or used to be) – this effectively decreases the amount of reimbursement that is not consumed by overhead. It is easier for dentists to just offer care without billing.
- The no-show rate may be as high as 50% for Medicaid insured.
- Delivery of dental care like "we always have" is not working – it is crisis oriented. Something else needs to be offered like continuous education.
- We are spending money post-disease, and not pre-disease.
- There is a mal-distribution of both dentists and hygienists in the state. Many dentists will retire in the next 15 years. Additionally, the decreasing number of dentists in the state will also have an impact on hygienist practice.
- Dentists locally have approached churches about taking their missions from other countries to a local setting, in order to specifically address dental care issues.
- Sometimes sealants for children are requested before they have had a proper exam.
- Dentistry is not like general medicine, but is more like surgery as a profession; the primary challenge is in the financing of dental services.

### Resources

- Dental Advisory Group – Northwest Health (corporate sponsor), currently working on creating a clinic that will accept payment based on sliding fee scales, as well as Medicaid and the uninsured.
- Elks Mobile Van; this program also pays dentists for some follow up care.
- The Northwest Dental Society has an annual meeting with legislators.

**Advice**

- Support Medicaid's budget that includes funds for increased reimbursement for dental services.
- Offer education about oral health during Lamaze classes or prenatal care.
- Advocate for more school-based education and fluoride application. St. Joseph schools have UMKC students run a clinic for this purpose.
- Churches in Nebraska have created a "welfare trust" that is used to help pay for services; a similar model could be explored in Missouri.
- Include the Parents-as-Teachers program as a partner in the Coalition.
- Look at tobacco settlement resources to help advance dental and oral health improvement.
- Need lobbying from local groups.
- Corrections facilities and jails have access to resources for the dental care of their inmates that might be applied to the broader community.
- The Coalition should support efforts to increase the Medicaid fee schedule, and efforts to fund or advance community education strategies aimed at young children and their parents.
- Public service announcements focused on oral health need to be developed.
- County level coalitions need to be formed across the state; these should include Head Start, PTAs, schools, and others who interact with children.
- The Coalition should devote its efforts to providing legislators with information about the scope of the problem and its solutions: the squeaky wheel gets oiled, and we need to identify the wheels in the state.
- In all strategies, support existing providers of dental care, before creating a new system.

## Kirksville

**Issues**

- The importance of dental care needs to be stressed through community education:
    - Dental sealants are underutilized
    - Strategies needed to reach parents better
    - Up to 30% no show for dental appointments
- People may not place a value on dental services if they do not pay for them.
- There are few dentists who accept or have room for Medicaid patients in their practices.
- From Medicaid: payment, timeliness of payment, and fear of fraud or error prevent participation in the program.
- There is a lack of capacity – practices are full, and if you are Medicaid insured you will wait longer to find a dentist.
- Children may not be taken to the dentist until they have a toothache.
- Head Start emphasizes early education, but there are few providers to see children on an ongoing basis after their initial screening. Parents may not value dental care for themselves which makes it difficult to communicate why screenings are required.
- The state reimbursement for sealants through counties takes some time; also, Medicaid is the "first" payer for this service for Medicaid eligible children, which means that verification and paperwork is required to find children who are completely uninsured and therefore eligible for the program.
- Education is not a substitute for concern or care.
- The community is seeing an increase in the number of minority workers and families; they may not be Medicaid eligible, and some have never had previous dental care.
- Lack of providers, especially those with a public health mindset and approach, and a general decrease in the number of dentists has created access and public health challenges.
- Children who have insurance other than MC+ are having a hard time getting timely dental appointments as well.
- There are some clinics, but there is difficulty in staffing them, which creates waiting lists for services.
- There is very little dental insurance in the population – and a lot of uninsured persons in general. Every provider has some uninsured persons in their practice. The elderly, and young women often have no dental insurance.
- Regulations and policies may get in the way of providing dental services, such as the proximity between providers.

- Baby bottle caries are a significant problem in the community.
- Changes in the Medicaid program for electronic filing have decreased the administrative burden somewhat: filing errors can be seen the next day and adjusted.
- If the target for reimbursement increases is an old "UCR," then in three years, we may not be at the target we expect (e.g., 75% of *current* UCR).

**Resources**

- UMKC/AHEC are working to expand rural training sites for dentists.
- There are federal loan repayment slots available in the state, but often positions are open with no one to fill them due to the lack of dentists. In rural areas, especially, it is difficult for private dentists to fulfill the requirements for loan repayment eligibility, which requires that they take all patients, regardless of ability to pay, and with whatever insurance (or lack of) that patients have.
- The state is proposing to include dentists in the PRIMO program (which is a state loan repayment program)
- Hannibal – volunteer dental clinic, which accepts and bills Medicaid
- Randolph County – Mid-Missouri dental clinic for MC+, receives United Way funding
- Northeast Missouri Dental Clinic
- Elks Mobile vans – 10-12 week rotating schedule around the state, depending on the need
- Head Start

*See information provided by State Dental Program*

**Advice**

- More training and education programs for dentists and dental professionals are needed, especially since the dental school in St. Louis closed.
- Higher education representatives need to be involved in the Coalition.
- There are three different payment systems for Medicaid: fee for service, managed care and cost-based reimbursement for community health centers. Which system works the best? Knowing that, can one system be implemented for the whole state?
- Increase the number of dentists and hygienists in the state of Missouri.
- Increase Medicaid fees and continue to decrease the administrative burden (e.g., by continuing to use the ADA form and decreasing restrictions and prior authorization)
- Continue to keep contacting patients who are Medicaid enrolled who do not show up for their appointment.
- Explore adding insurance company representatives as members of the Coalition.
- Keep solutions simple.
- Continue prevention activities.
- Encourage the state to invest in a long-term workforce strategy and aggressive recruitment.
- Balance immediate with long-term needs.
- The Coalition needs to be based in a network of community level coalitions focused on this issue; take the issue to the community level where it is not (county and town level), use CHART and existing Caring Communities to take the issue on, as well as other existing groups.

## Columbia

**Issues (see sheet of statistics and information compiled by Boone County Report Card Committee)**

- Chronic dental problems due to lack of access for those persons with "straight" Medicaid (non-capitated Medicaid); moms and children are most often the population that is in the capitated Medicaid program.
- There are approximately 43,000 MC+ covered persons in 18 counties in central Missouri; less than 20% have access to care. About 10,000 of those persons have "straight" Medicaid.
- Elderly persons in both nursing homes and communities lack access to dental care; this exacerbates chronic disease, if they have one.
- Transportation is problematic, and lack of transportation increases the amount of time off from work required to obtain services.
- The lack of education and knowledge about the importance of oral health means that people do not put a priority on their teeth.
- There is a shortage of dentists and dental hygienists in the state, and only one dental school.
- Persons with commercial insurance coverage have to wait for dental appointments.
- Infrastructure problems: there is a lack of capacity in terms of both the number of providers as well as programs for persons who do not have insurance or Medicaid insurance. AHEC is recruiting providers to the state as part of addressing this issue.
- Challenges with the Medicaid system: paperwork, low reimbursement, patient reluctance to be treated as a "welfare case."
- There is no preventive care for those persons who are "straight Medicaid" in Boone County.
- People may have eligibility for programs, but not accessibility.
- There is the possibility that a lawsuit could be filed against the state for not providing adequate access to Medicaid insured persons.

*Local Dental Health Report Card/Committee Goals*

- Provide 40 visits a week for "straight Medicaid" patients.
- Increase utilization of MC+.
- Adult dental pain relief program—uses volunteer dentists; $18,000 per year funded by the United Way and the County; sometimes up-front co-payment for this program is refunded to people, because the waiting time is so long for services, they need an alternative or learn to live in pain.
- Family Health Center dental plan.
- Free dental clinic in Jefferson City where dentists volunteer; AHEC helps to organize the administrative piece. AHEC plans to replicate this model

in other counties across the state (note: there is a conference in the Spring of 2001 on this topic).

**Resources**

- Tobacco settlement resources should be used to finance dental and oral health strategies.
- King's Daughters program helps uninsured children (not on the Medicaid program) find dental care.
- Camden, Phelps and Lincoln Counties all have dental initiatives of some kind.
- Elks Van – may receive funding from the state; this needs to be explored.
- The United Methodist Church has dedicated a staff person for an entire year to determine how the church can contribute to resolving this issue, what resources they can contribute and how to best be involved. Twenty percent (20%) of collections will be devoted to addressing this issue.

**Advice**

- The Coalition needs to be a source of information and best practices for communities or organizations interested in establishing dental programs; for example, have information on hand about the Federal Tort Claims Act and how it protects volunteer dentists. Research liability issues for free clinics.
- Sponsor a discussion with the University of Missouri around a general dentistry residency program – the time is right with leadership changes to explore this issue, and could involve the school of public health, the nursing school and the dental school. In the past this has been explored, and resources are needed for training programs, but it would be worth exploring again.
- The Coalition's role could be to help focus oral health advocacy efforts to the legislature – lobbying is needed! Consider the addition or development of a legislative committee for the Coalition.
- Consider an "Outreach Committee" for the Coalition, which would continuously bring in new members, and communicate resources available.
- The Coalition could develop a web page as a way to keep everyone apprised of key issues, strategies and progress—and as a way to link communities to each other around this issue. Anecdotal information and stories could be a part of the website, and would also be valuable for lobbying efforts.
- Focus on linking people together and providing information.
- Loan repayment should be offered as an incentive for dentists serving in rural areas.
- Add nurses to the Coalition, who see dental needs they can't address.

- Secure resources to provide reimbursement for dental education and offset the cost of technology required to establish a new dental practice.
- Explore hygienists possibly practicing in public health setting.
- Simms Bill (if passed) will address the hygiene needs of children; need to advocate that this be expanded to adults.
- Advocate for the Medicaid program to have the staff and technology resources necessary to do quick reimbursement.
- Find strategies that provide an accurate and up to date source of dentists available for Medicaid patients (note: the Medicaid office suggested that calling the Medicaid office directly was the best approach given how quickly the list changes). Local coalitions could also take responsibility for maintaining a "list" in a way that works for both dentists and patients.
- Appeal to dentists' sense of volunteerism.
- Educate medical providers about dental disease and how/when to do dental screenings and make referrals.
- Enforce mandatory oral check by CNAs in nursing homes.
- Faith based organizations and corporations need to be members of the Coalition.
- The dental needs of our growing Hispanic population, especially children under age 5 need to be addressed.
- Develop a 5-7 minute video that could be used to educate legislators.
- Develop strategies that effectively connect oral health to overall health, such as by developing an education packet or approach for physicians/pediatricians.

## Poplar Bluff

**Issues**

- Emergency oral health needs are overwhelming.
- Dental capacity is insufficient; specifically there are not enough dentists. Missouri is losing 70 dentists per year, there is only one dental school in the state and rural areas are hit harder by this deficiency.
- People travel up to one hour for care.
- Compliance with appointments and maintenance of oral hygiene.
- Medicaid reimbursement is low, slow and involves lots of paperwork. Reimbursement should be at 75% of charges to meet dental overhead (63-67%) and have it be feasible for dentists to see patients.
- The bureaucracy of programs and reimbursement is forcing private dentists from the system.
- Graduates from dental school have large debt loads.
- The cost of establishing a dental practice (equipment, staff) is prohibitive; therefore, many dentists don't set up practices in rural areas.
- Transportation is a major barrier to accessing services, and many Medicaid enrolled persons are not aware of what transportation services are available to them.
- People who are working but do not have insurance, and those who suffer from drug or alcohol abuse may make too much money to qualify for Medicaid but not enough to pay for dental care; therefore they wait until the pain or the problem is acute.
- Awareness of what is available and the appropriate way to access services is a challenge.
- Pediatric dental care is a need in all parts of the state.
- There is a lack of providers to refer persons eligible for Medicaid or MC+ -- communities need to broker relationships and develop networks of providers.
- Dental health insurance coverage even from private plans is inadequate.
- Health and dental health are low priorities for many people – particularly if they are poor and live in crisis.
- There is a disconnect between prenatal care and good oral health care – baby bottle tooth decay is a major problem.
- Lack of fluoridated water sources in the state – private wells in many rural areas.
- Consumers, policy makers and insurers all put a low priority on dental health; it is not fully accepted as part of overall health, and unhealthy lifestyles and behaviors contribute to poor oral health (poor diet, smoking).
- Parents do not have the knowledge necessary to pass on good oral health and hygiene to their children.

**Resources**

- Private providers, both for adults and pediatrics; many dentists see 30-50 patients a day, and as many as 50% of patients from this region may be Medicaid eligible. Some dentists are booked until April 2001.
- Sealant programs
- AHEC
- UMKC
- Dental hygienists
- Health Departments, which do dental screenings
- Community Health Centers
- Fluoride rinse programs
- Head Start
- Caring Communities

**Advice**

- Educate consumers with strategies that are intense, frequent and simple.
- Educate providers and those who make referrals about what resources are out there and what activities are happening, what policies are in place and what best practices they might put in place in their offices.
- Promote ways and places for providers to come together (e.g., Head Start, private dentists, other service providers) so they can understand each other better, and how each is trying to solve a piece of the problem. This is especially needed for community health centers and private providers to promote partnerships: community health centers support both private providers and the entire health system. Private dentists perceive that centers are profiting from serving the poor and are receiving enhanced reimbursement. There is a negative history and experience in the dental community with federally supported programs.
- Promote community wide efforts to recruit providers.
- Educate policy makers about the shortage of dental professionals. Give them information that will allow support for increases in home grown dental students. The state of Illinois has a good model.
- Work together to influence the academic pathways to dental practice: curriculum changes to support the profession, even at the high school level; rural rotations for dental students, etc.
- Consider reimbursement changes: if the patient of a federally qualified health center is seen at the FQHC or at a dental office, the same reimbursement should be provided. This would require staffing changes, contracts, policy changes and both state and local support.
- Promote more “insurance” vs. “reimbursement” strategies: if under 100% of the federal poverty level, your insurance pays all; if you are between 100 and 300% of the federal poverty level, you pay some and your insurance pays some.

- Share responsibility for dental health promotion and disease prevention.
- Advance strategies and funding that helps new dental school graduates to pay off their loans.
- Reimburse providers in rural areas more from public programs.
- Medicaid and MC+ need to stay heavily invested in community awareness around eligibility, outreach and enrollment.
- Coordinate activities and data in the state around oral/dental health.
- Model the Head Start approach for getting families and children to dental services, especially their aggressive follow up services.
- The group convened at this meeting should continue the dialogue around opportunities to improve access to dental services and improved oral health.

## Kansas City

**Issues**

- There are several changes that would make the Medicaid program more efficient, so that it can effectively compete with other insurance plans for dentists' attention and cooperation:
  - Claim should automatically have a "D" in the codes
  - Automatic quantity should be "1" on the claim form
  - Goal for the program would be to have 98% claims success on the first submission. 30-50% of the claims need to be resubmitted; this is not a problem with other insurers.
  - Should investigate the development of some kind of "super bill"
  - Claim denial – office should be called or emailed with what to do to fix the denial
  - Too many dates on the form; should be one date
  - Patient numbers are confusing: number on the Medicaid card? Or on their HMO card?
  - Not always clear where to send claims
  - Phone number for claims discussion is always busy; get more staff or more phone lines. Shorten the phone menu and make the menu user-friendly.
  - Newsletter from the Medicaid program that goes to dentists should have dental specific information only
  - Increase the reimbursement for dentures.
  - Oral surgeons and endodontists won't take Medicaid – the program needs to focus its efforts on recruiting specialists to be a part of the program. Usually it takes a special deal for these providers to participate in the program. Retaining dental specialists is also a problem for private insurance companies.
- Simple treatment is not occurring for many and the problem is compounding.
- As long as Medicaid reimbursement is lower than other payers, and patients are problematic for dentists to treat, there will continue to be few dentists to treat the Medicaid insured population. Dentists would rather do free care than take Medicaid.
- Dentists cannot meet existing demand, and higher Medicaid reimbursement may not help to actually get more people seen in private dental practices.
- Depending on who you talk to, there is either a shortage or mal-distribution of dentists, hygienists or both, in the state of Missouri. There are actually fewer than 1800 general dentists practicing in the state. There is not enough of either practitioner in rural areas of the state.

- Many dentists on the “list” of providers for MC+ may not be accepting new patients.

**Resources**

- Sealant project with schools (Kansas City) using hygienists and portable equipment is very successful.
- Free clinic, open 14 hours a week. Typical patient is a young man between the ages of 20-30 who is working for minimum wage, at several jobs, without insurance.
- KCMC Child Development (Head Start) has agreements from 3 dentists to provide screenings for children, and also contracts with 5 dentists. Dr. Kindricks is providing a presentation for parents in the near future.
- Platte and Clay Counties – have a program in place that could use the Coalition's support.
- Dental Alliance (spouses of dentists) – losing people over time, but is a resource to provide basic education to various groups.
- The Seton Center—Family and Health Services
- Missouri Department of Public Health literature library has outstanding materials.

**Advice**

- The Coalition could monitor the resources that Medicaid allocates to various programs; sometimes there is money left over that reverts back to the state and is used for other purposes. These resources could be used to fund desperately needed prevention efforts for the Medicaid eligible population.
- The Coalition needs to have an aggressive campaign to educate the legislature and encourage them to invest more in oral health.
- The Coalition needs to increase awareness in the state about what legislative initiatives are actually being considered in the session, and how individuals and organizations can support legislative initiatives.
- Dental hygienists need to be used more creatively and extensively to do prevention and education programs in all kinds of settings. A successful Canadian program had teams of dental hygienists visiting schools across the province providing education, screening and identifying high-risk cases to refer to dentists. Create opportunities for hygienists to educate through health departments and schools. Competitive reimbursement for dental hygienists would be needed to implement these programs.
- Encourage each dentist to "take small bites" – just a few patients.
- Heavily investigate models from other states, such as the Washington State ABCD model.
- The Coalition needs to add members from social service organizations.
- Advocate for increased volunteerism but also work on developing sites and programs where dentists can effectively donate their time.

- Focus on prevention, especially for women and children: do the basics of screening and triage. Dentists, hygienists and physicians all need help with screening and basic oral health education materials.
- Heavily involve Head Start, which has the best ability to reach parents.
- Investigate the Nebraska "Medicaid School" which is a program for newly enrolled Medicaid persons that explains how and when to use the system. This is an opportunity to present how important dental care is and why it is important to keep dental appointments. Determine if mandatory oral health training of some kind can be worked into Medicaid eligibility and other assistance programs.
- Implement a Big Brothers/Big Sisters program, so older siblings can help younger ones to learn to brush and floss, etc.
- Provide patient/parent/young child education via Internet based modules, that can serve as the examples or content for school based classes on how to use the Internet, or other technology classes.
- Advocate for the needs of the elderly, as well as for children.

**Case Study:**
**Kansas City Providers of Dental Services for Underserved**

- Swope Parkway Community Health Center: 4 Full time dentists
- Sam Rogers Community Health Center: 2.6 dentists, 2 assistants, rotation program with UMKC for dental hygienists
- Cabot Health Clinic: 1-2 dentists
- Free Clinic: 2 nights per week, 1 dentist
- Doctors with a Heart: 1 day per year of volunteer dentistry

## Springfield

**Problems/Issues**

- Lifestyle and behavioral issues
  - Parents inadequately educated about dental care for infants (bottles through the night) and children (diet, brushing and flossing)
  - Schools creating the opportunity for children to damage their teeth by permitting soda and snack machines in the schools (Advice: can we put more juices, fruits and alternatives in the machines?)

- Poor reimbursement process for private dentists through Medicaid
  - Medicaid reimbursement amount is below 50% of usual and customary costs
  - Administration surrounding the Medicaid reimbursement process: paperwork, telephone bureaucracy and lack of consistent case worker (no person to work with)
  - Note: the Medicaid office is beginning to address these issues with efforts to increase the reimbursement amount, initiating electronic filing, and hiring more staff to handle case load

- Provider capacity
  - Many dental providers are at capacity or unwilling to take new patients, particularly Medicaid
  - Dental providers are nearing retirement age and have reduced hours
  - Manpower is low; no replacements
  - Lack of loan repayment programs for dental students
  - Lack of dental providers -- not enough dentists to even see paying patients
  - Dental providers not trained/ready to handle the Medicaid population (bring-in multiple issues: social, cultural, dress/appearance, and compliance – missing appointments)
- Language and cultural barriers
- Medicaid patients are coming to the emergency room and their primary medical care providers for dental care.
- Lack of dental prevention
- Influx of patients from surrounding communities
- Greene Co. Health Dept. has a waiting list through March 2001

**Resources**

- The Springfield clinic has established a volunteer opportunity for dentists, but the clinic is assigned the provider number for billing purposes, so dentists can remain "anonymous."
- Greene County has also been the location of the Miles for Smiles program.
- Taney County Initiatives
- Health Department Dental Clinic
- Schools (Nurses)
- ERs
- Some private providers
- Faith community

**Advice**

- Establish mobile dental units to travel to schools and surrounding communities (a source of regular/routine care or an entry point in to the dental health system).
- Engage Universities: role in education, research and training; dental student rotations.
- Water fluoridation education and advocacy strategies are needed.
- Look at Dallas County model as a best dental health practice (advocacy and implementation).
- Advocate for reimbursement changes – pay for an FQHC patient at the FQHC rate no matter where they are seen.