REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

DENTAL STUDY PURSUANT TO HJR 644

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 86

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

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Patrick W. Finnerty

Preface

House Joint Resolution (HJR) 644 of the 1999 Session of the General Assembly directs the Joint Commission on Health Care to study ways to increase access to dental care throughout the Commonwealth.

HJR 644 requires the Joint Commission to conduct its study in cooperation with the Virginia Department of Health, the Department of Medical Assistance Services, the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Virginia Commonwealth University School of Dentistry, the Virginia Board of Dentistry, the Virginia Association of Free Clinics and the Virginia Health Care Foundation. Specifically, the study is to include, but not be limited to, an analysis of:

(i) the need for practitioner data for dental workforce planning purposes;
(ii) the financial, structural and other barriers to accessing dental care throughout the Commonwealth;
(iii) dental practitioner shortage areas and ways to increase the number of dentists practicing in these shortage areas;
(iv) the number of dentists participating in the Medicaid program and actions that would increase the number of participating dentists;
(v) the current dental scholarship program, and potential revisions to the program that may increase the number of dentists establishing practices in underserved areas;
(vi) the actions taken in other states to increase access to dental care and to increase the number of dentists participating in Medicaid and practicing in underserved areas; and
(vii) other appropriate issues which will increase access to dental care.

A copy of HJR 644 is attached at Appendix A.

Based on our research and analysis during this review, we concluded the following:

- The overall ratio of dentists to population in Virginia is favorable; however, there are 43 underserved areas in Virginia. Only 10 of these areas have been designated as dental heath professional shortage areas (HPSAs) by the Virginia Department of Health (VDH). This limits the ability of Virginia to attract dentists participating in the National Health Services Corps Loan Repayment program.
- Very few dentists participate in the Virginia Dental Loan Repayment Program. There is no Dentist Loan Repayment Program similar to the

physician loan repayment program. The Dental Hygienist Scholarship program has never been funded.

- Recently, the number of patient visits and dental services at public clinics has declined. VDH reports it has difficulty recruiting and retaining Public Health Dentists due to low salary. Public health dentists earn about one-half of a private practicing dentist.
- During FY 1996-1998, $19.4 million was appropriated for dental services at local health departments; however, $3.5 million of this amount was spent on other health care services. There is anecdotal evidence that several of the "dental trailers" used by local health departments are in need of equipment upgrades, and others are under-utilized.
- There are 56 communities in Virginia which do not have access to public health dental services, further study is needed to determine the feasibility of extending services to these communities.
- Currently, there are very limited opportunities for dental students to gain exposure to practicing in underserved areas. The MCV dental school is developing plans for an externship program to enhance students' experiences in these areas. Implementing such a program would require funding for faculty supervision and other expenses.
- Currently, Medicaid provides dental coverage only for children. Only about 25% of eligible actually receive dental services paid for by Medicaid. Over the past several years, there has been a declining number of dentists participating in Medicaid. The General Assembly has directed DMAS to take steps to increase the number of participating providers, including increasing the reimbursement to the 85th percentile of UCR based on commercial insurer data.
- Medicaid dental coverage is not offered to adults. 27 other states offer dental coverage to Medicaid adults. Consideration should be given to providing dental benefits to Medicaid adults.
- Virginia is one of only 7 states that require "direct supervision" of dental hygienists for all services provided in all practice settings. Easing supervision requirements for providing basic services such as cleanings and dental sealants may improve access to services in certain settings such as dental HPSAs, public health clinics, free clinics, community health centers, and schools. Less restrictive supervision would not involve expanded scope of practice, independent practice or direct reimbursement. If desired, regulations could require certain hygienist qualifications or a minimum amount of experience. The Virginia Dental Association strongly opposes less restrictive supervision of dental hygienists.
- Virginia is one of 16 states that do not allow "licensure by endorsement" for dentists. Dentistry is the only health profession in Virginia that does not permit this form of licensure. A 1999 JLARC

study found that the lack of such a practice does not appear to be related to protection of the public and appears to create a barrier to entry for out-of-state dentists.

- Consideration should be given to allowing "licensure by endorsement" for dentists who agree to practice a given percentage of time in a dental HPSA, at a free clinic, a public health clinic, or community health center.
- Given the breadth of issues regarding access to dental care, the HJR 644 study was not able to address issues such as increasing the number of persons with dental insurance, and collecting additional practitioner data on dental hygienists. Also, the number of dentists participating in Medicaid and the number of eligible children receiving dental services should be monitored further. Consideration should be given to continuing the dental study in 2000.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 47-49.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at Appendix B) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Virginia Department of Health, the Department of Medical Assistance Services, the Virginia Dental Association, the Virginia Dental Hygienists Association, the Virginia Primary Care Association, the Virginia Association of Free Clinics, the Virginia Health Care Foundation, the MCV School of Dentistry, the Virginia Community College System, the dental hygiene schools, and the Virginia Board of Dentistry for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

December, 1999

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I.
Authority for Study/Organization of Report

House Joint Resolution (HJR) 644 of the 1999 Session of the General Assembly directs the Joint Commission on Health Care to study ways to increase access to dental care throughout the Commonwealth.

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(vi) the actions taken in other states to increase access to dental care and to increase the number of dentists participating in Medicaid and practicing in underserved areas; and
(vii) other appropriate issues which will increase access to dental care.

A copy of HJR 644 is attached at Appendix A.

This Report Is Presented In Six Major Sections

This first section discusses the authority for the study and organization of the report. Section II discusses the importance of dental care and oral hygiene. Section III provides information on the dental workforce in Virginia. Section IV discusses the level of dental care provided in the Commonwealth. Section V examines potential ways of improving access to dental care in Virginia. Lastly,

Section VI presents a series of policy options the Joint Commission may wish to consider in improving access to dental care throughout the Commonwealth.

II.
Importance of Dental Care and Oral Hygiene

Research Indicates That Proper Dental Care And Oral Hygiene Can Significantly Reduce Tooth Decay And Dental Disease

Unlike most medical problems, which affect only certain persons or segments of the population, there is near-universal incidence of dental disease. While dental disease can affect everyone, a proper program of dental care and oral hygiene can significantly reduce the incidence of tooth decay and dental disease. In fact, the American Dental Association (ADA) states that dental disease is almost entirely preventable. Researchers believe that due to advances in fluoride treatments and dental sealants, dental caries (cavities) and tooth loss (for reasons other than injury) virtually can be eliminated with appropriate and regular care.

While the advances in dental care have resulted in improved oral hygiene and hold even greater promise for future generations, tooth decay and other types of dental disease continue to pose serious health problems.

Recent Studies Have Concluded That While There Have Been Improvements In The Nation's Dental Health During The Last Few Decades, Problems Still Exist

The National Institute of Dental Research (NIDR) sponsored the oral health component of the National Health and Nutrition Examination Survey (NHANES). Released in 1996, the findings of the survey indicate that there has been substantial improvement in the nation's dental health over the past couple of decades. However, the NHANES also concluded that a number of serious problems continue to exist, particularly for certain segments of the American population.

The NHANES found that the number of children without dental caries (cavities) has increased from 50% in 1987 to 55% in 1994. However, the NIDR cautions that despite advances in fluoride treatments and dental sealants, 45% of children still suffer from this preventable infectious disease. Moreover, dental caries are not distributed evenly among children and adolescents. Eighty percent of the caries were found in only 25% of children. Although black and white youngsters had about the same amount of caries in their permanent teeth, black children had more than twice as much untreated decay as did white children.

The impact of untreated dental disease for children is significant. Extensive tooth decay, pain or infection can cause eating, learning, and speech problems for children. An article published in the American Journal of Public Health estimated that on a national basis 52 million school hours are missed annually by children because of oral problems. This equates to more than 850,000 school days each year. In this same article, it is estimated that U.S. children and adults from lower-income, less educated and uninsured groups have experienced more than 41 million restricted-activity days annually because of dental problems.

Dental disease in American adults also continues to pose problems. Researchers analyzing the NHANES survey results note that tooth decay is nearly universal among American adults. The survey found that 94% of persons age 18 or older had either untreated decay or fillings in the crowns of their teeth. Moreover, survey findings indicate that nearly 62 million American adults who had teeth had at least one tooth or tooth space that might benefit from treatment.

Recent Research Indicates That Untreated Dental Disease Can Have Serious Adverse Affects On Patients' General Health

Untreated dental disease can lead to infections in the mouth and other craniofacial areas. These infections can produce severe pain and lead to emergency conditions that often require tooth extractions. While it has long been recognized that untreated dental disease can be painful and result in lost school or work days, recent research has shown a relationship between dental disease and other serious health conditions.

There is an increasing body of evidence that suggests periodontal (gum) disease may precipitate or aggravate health problems elsewhere in the body. Infections in tissues of the mouth are easily spread into the bloodstream. Once into the bloodstream, these infections can result in serious health problems.

Heart Disease: According to the American Academy of Periodontology, there is accumulating evidence that identifies periodontal disease as significantly increasing the risk for heart disease and as a risk factor for cardiovascular disease. All other things being equal, people with periodontal disease are one and a half to two times as likely to suffer a fatal heart attack and nearly three times as likely to suffer a stroke. The association with heart disease is especially strong in people under 50.

Studies have indicated that chronic oral infections can foster the development of clogged arteries and blood clots. Substances produced by oral bacteria that enter the bloodstream can precipitate reactions that result in a build-

up of arterial deposits. Several common oral bacteria can initiate the formation of blood clots and disrupt cardiac function.

Diabetes: Scientists have known for some time that diabetes predisposes people to bacterial infections, including infections of oral tissues. However, recently, studies strongly indicate that periodontitis can make diabetes worse. Diabetic patients with severe periodontitis have greater difficulty maintaining normal blood sugar levels. Conversely, treatment of periodontitis often results in a reduced need for insulin. Medical and dental professionals urge that periodontal inflammation be treated and eliminated in all people with diabetes.

Pneumonia: Bacterial pneumonia results when bacteria that live in the mouth and throat are inhaled into the lungs, where immune defenses are inadequate. Several bacterial agents that can cause pneumonia can thrive in infected oral tissues of persons with periodontitis. In addition, other respiratory diseases, such as chronic bronchitis and emphysema may be worsened by oral infections when the bacteria are inhaled.

Premature Birth: Evidence that periodontal disease may be associated with premature births is just developing. Infections of the pelvic organs long have been known to be associated with premature labor. However, recent studies suggest that oral infections also can induce premature labor. While there has not been a substantial amount of research in this area, one small study found that mothers of prematurely born small babies are seven times more likely to have advanced periodontal disease.

The U.S. Surgeon General Is Conducting A Comprehensive Analysis On The Nation's Oral Health

The growing evidence of the linkage between oral health and general health has prompted the U.S. Surgeon General to conduct a comprehensive study on the nation's oral health. The National Institute of Dental and Craniofacial Research (NICDR) has lead responsibility for the study. The broad objective of the study is to: *"define, describe and evaluate the interaction between oral health and general health and well-being (quality of life), through the life span, in the context of changes in society."*

The major elements of the study will be to:

(i) examine the relationships among oral disease, general health status, and systemic diseases;
(ii) explore the effects of oral health on daily living and quality of life;

(iii) describe the magnitude of the problem, including dental caries, periodontal diseases, and others, and assess the causes, incidence, prevalence, demographics, costs and care delivery;
(iv) identify factors that prevent disease and promote good oral health, and identify barriers to achieving these outcomes;
(v) examine oral health and well-being within the context of life stages and cycles;
(vi) evaluate the effects of new and emerging science and technologies on oral health and suggest ways these can be accelerated into application; and
(vii) develop initial recommendations based on the state of the science and evidence-based practice.

Public health officials and dental professionals point to this report as being evidence of the fact that the federal government is placing a heightened importance on oral health and access to dental care. The report is expected to be released in late 1999 or early 2000.

III.
Virginia's Dental Workforce

Dental Care Is Provided By Licensed Dentists And Dental Hygienists

Dental care is provided by dentists and dental hygienists who are licensed according to the *Code of Virginia*. Dental assistants provide important services in the dental office; however, the level of clinical services is limited. The following paragraphs outline the pertinent provisions of the *Code of Virginia* and the Board of Dentistry regulations which govern the licensure and practice of dentists and dental hygienists.

Dentists: Section 54.1-2709 of the *Code of Virginia* states that applicants for licensure as a dentist must: (i) be of good moral character; (ii) be a graduate of an accredited dental school or college, or dental department of a university or college, and; (iii) perform satisfactorily on the examination.

Section 54.1-2710 of the *Code of Virginia* states that it shall be unlawful for any person to practice dentistry or to receive a license from any commissioner of the revenue to practice dentistry, unless he has passed the examination and obtained a license. This provision prohibits the practice of "licensure by endorsement" for dentists in which a health professional who is licensed in another state and meets certain other criteria or credentials can be licensed without having to take the clinical examination.

To practice in Virginia, a dentist must hold a current, valid, "active" license. The Board of Dentistry also provides "inactive" licenses to dentists who have been fully licensed in the Commonwealth and do not wish to practice in Virginia. The Board of Dentistry also issues a faculty license for full-time faculty dentists and limited or "restricted" licenses to dentists desiring to: (i) provide volunteer services at a Board-approved clinic; (ii) teach dentistry; or (iii) teach dentistry for foreign dentists.

The Board is considering legislation that would amend §54.1-2709 to eliminate the ability of dentists who have practiced in another country to be licensed in Virginia so long as the dentist has practiced in the other country for five consecutive years prior to application. The proposed legislation also would require applicants for a dental license to be a graduate of a pre-doctoral program leading to a DDS or D.M.D. degree accredited by the Commission on Dental Accreditation of the American Dental Association. (Currently, the *Code of*

Virginia also allows an applicant for licensure to be a graduate of an accredited dental school, college or dental department of a university of college.)

Dental Hygienists: Dental hygienists are licensed pursuant to §54.1-2722 et. seq. of the *Code of Virginia*. Section 54.1-2722 requires dental hygienists to practice dental hygiene under the "direction" of a licensed dentist. The term "direction" is defined in regulations adopted by the Board (18 VAC 60-20-10) to mean "the presence of the dentist for the evaluation, observation, advice, and control over the performance of dental services." Regulations promulgated by the Board of Dentistry (18 VAC 60-20-200) further state that "the dentist shall be present and evaluate the patient during the time the patient is in the facility."

Dental hygienists must submit an application for licensure accompanied by satisfactory proof that the applicant is of good moral character and a graduate of an accredited dental hygiene program approved by the Board and offered by an accredited institution of higher education. Licensed dental hygienists may, under the direction of a licensed dentist, and subject to the regulations of the Board, perform services which are educational, diagnostic, therapeutic or preventive. These services do not include the final diagnosis or treatment plan for a dental patient.

As with dentists, the Board provides an "inactive" license for those dental hygienists who have been fully licensed in the Commonwealth and do not wish to practice in Virginia. To practice in Virginia, dental hygienists must hold a current, valid, and "active" license. The Board also grants: (i) licenses to teach dental hygiene, (ii) temporary permits for certain dental hygienists to serve in the Department of Health or the Department of Mental Health, Mental Retardation, and Substance Abuse Services; and (iii) restricted volunteer licenses for dental hygienists who practice only in public health or community free clinics approved by the Board.

While the Code prohibits "licensure by endorsement" for dentists, the regulations adopted by the Board provide for "licensure by endorsement" for dental hygienists. The regulations (18 VAC 60-20-80) provide that dental hygienists who meet the following requirements can be licensed without taking the clinical licensing examination. Dental hygienists need to:

- Be a graduate of an accredited dental hygiene school/program;
- Be licensed to practice dental hygiene in another state;
- Be certified to be in good standing from each state in which currently licensed;
- Have successfully completed a clinical licensing examination substantially equivalent to that required by Virginia;

- Not have failed the clinical examination accepted by the Board within the last five years;
- Be of good moral character;
- Not have committed any act which would constitute a violation of §54.1-2706 of the *Code of Virginia* (dealing with the revocation or suspension of a license);
- Have successfully completed the dental hygiene examination of the Joint Commission on National Dental Examinations; and
- Have passed an examination on the laws and the regulations governing the practice of dentistry and dental hygiene in Virginia.

As with dentists, dental hygienists must renew their licenses annually.

Board Of Dentistry Regulations Provide Further Direction Regarding The Provision Of Dental Care In The Commonwealth

The regulations promulgated by the Board of Dentistry provide more specific direction regarding the practice of dentistry and dental hygiene.

Regulation 18 VAC 60-20-190 specifies 13 non-delegable duties of dentists, including final diagnosis and treatment planning, performing surgical or cutting procedures on hard or soft tissue, operation of high speed rotary instruments in the mouth, performing pulp capping procedures, administering and monitoring general anesthetics and conscious sedations, final positioning and attachment of orthodontic bonds and bands, and final cementation of crowns and bridges.

Other regulations promulgated by the Board that relate to the issues to be addressed in this study include the following:

- Dentists are required to provide the Board with a current, primary *business* address; dental hygienists, however, must provide a current *resident* address. (18 VAC 60-20-16)
- Dentists cannot direct more than two dental hygienists at one and the same time. (18 VAC 60-20-200)
- Certain duties can be delegated only to dental hygienists, including: scaling, and root planing of natural and restored teeth, polishing of natural and restored teeth using air polishers, performing an original or clinical examination of teeth and surrounding tissues, and subgingival irrigation or subgingival application of Schedule VI medicinal agents (18 VAC 60-20-220).
- Oral health education and preliminary dental screenings in any setting and recording a patient's pulse, blood pressure, temperature, and

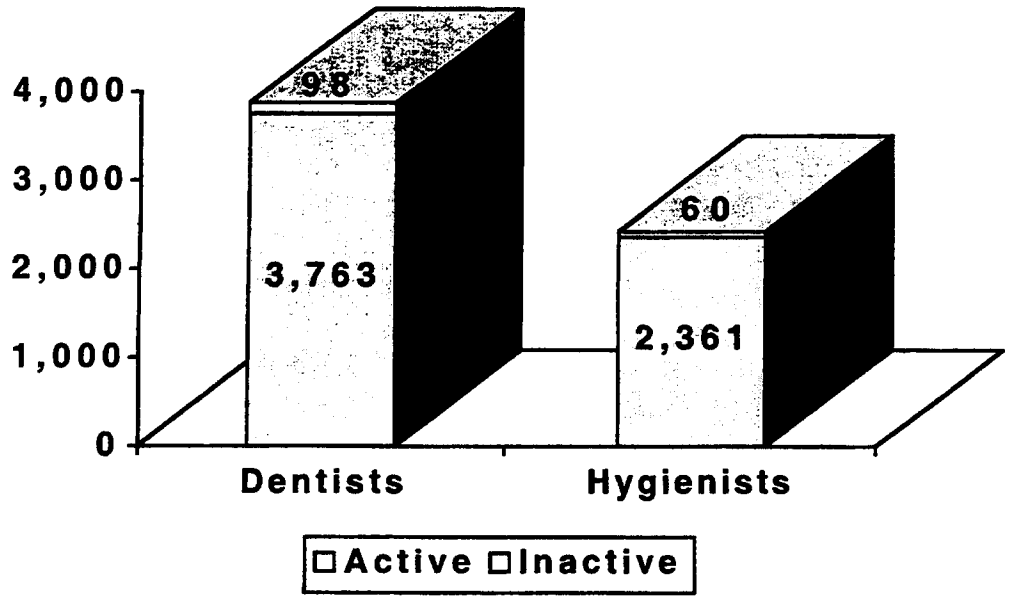
medical history are not considered the practice of dentistry or dental hygiene (18 VAC 60-20-240).

There Are Approximately 3,800 Active Dentists And 2,400 Dental Hygienists Licensed In Virginia

According to statistics maintained by the Board of Dentistry, as of June, 1999, there were 3,763 active dentists and 2,361 active dental hygienists licensed in Virginia. Figure 1 illustrates the number of dentists and dental hygienists who hold active and inactive licenses.

Figure 1

Number of Licensed Dentists and Dental Hygienists Practicing in Virginia (June, 1999)



Source: Virginia Board of Dentistry

The number of licensed dentists and dental hygienists in Virginia has increased over the past several years. Statistics maintained by the Board of Dentistry do not track active and inactive licensees as illustrated in Figure 1. Historical data reflect total licensees, which include those who are licensed but not practicing in Virginia. As seen in Figure 2, the total number of licensed dentists has increased from 4,602 in1990 to 5,177 in 1998, reflecting a 12%

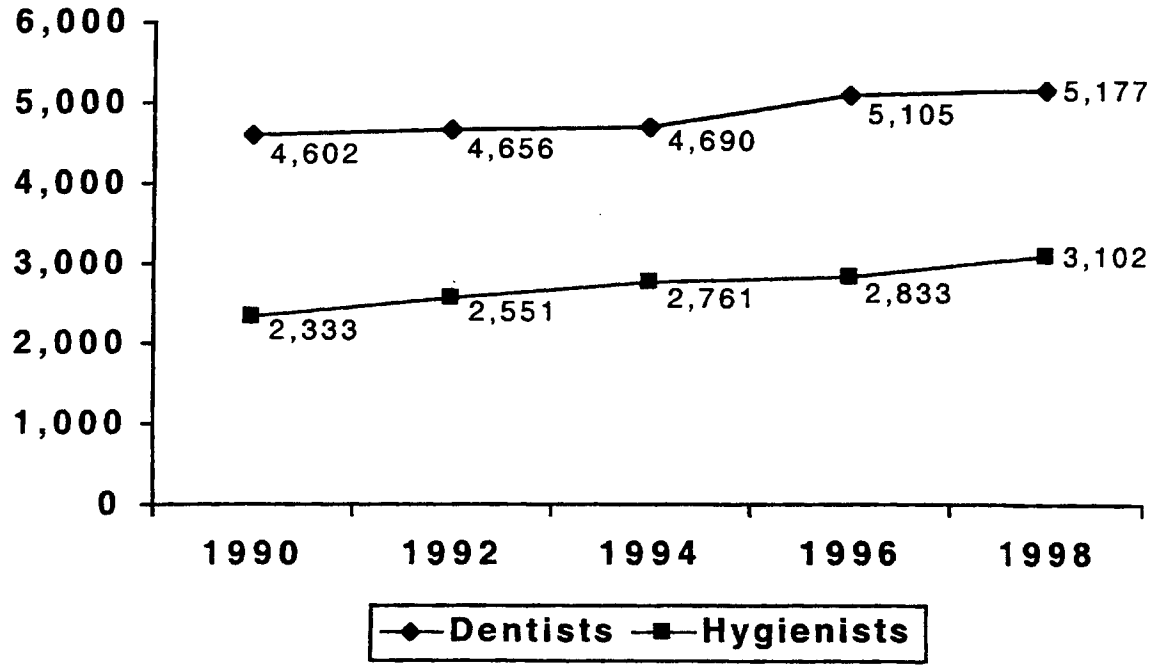
increase during this period. The total number of licensed dental hygienists has increased from 2,333 in 1990 to 3,102 in 1998, a 33% increase over the same time period.

The Board of Dentistry Collects Minimal Data On Licensed Dentists And Dental Hygienists

The Board of Dentistry collects minimal data on dentists and dental hygienists; however, the information is sufficient for the Board to regulate the practices. For dentists, the annual license renewal form includes the following data elements: name, business address, license expiration date, license fee, renewal period, social security number or Virginia DMV control number, and license number. For dental hygienists, the same data elements are collected, except that dental hygienists provide their home address rather than a business address.

Figure 2

Total Number of Dentists and Dental Hygienists Licensed in Virginia (1990 – 1998)



Source: Virginia Board of Dentistry

The American Dental Association Collects Detailed Information On Dentists; There Is Little Additional Information Collected On Dental Hygienists

While the information that the Board of Dentistry collects on dentists is limited, the American Dental Association (ADA) collects detailed information on dentists. The ADA's Survey Center collects, compiles, analyzes and disseminates various statistical data regarding the dental profession. The data available from the ADA Survey Center are comprehensive and include information on dental practice, dental workforce, educational and institutional issues, and other reports on specific areas of interest. One of the more useful reports published by the ADA is its State and County Demographic Report. This report is prepared on an annual basis and provides comprehensive information on the number of dentists, their geographic location, occupational status, and dentists' self-reported area of practice, research or administration.

The ADA information is an important supplement to the data collected by the Board of Dentistry and supports area-specific analyses of dental practices and dental workforce issues.

Information On Dental Hygienists Is More Limited: While data available through the ADA is extensive and supports dental workforce analyses, there are no comparable data collected on dental hygienists on a continuing basis. Because the Board of Dentistry collects the hygienist's *home* address during the renewal process, there is no ongoing source of information of where dental hygienists work. Moreover, while the Board can distinguish between hygienists who hold "inactive" and "active" licenses, there is an unknown number of hygienists who hold active licenses but who are not currently practicing.

While there have been surveys of dental hygienists conducted at various times in the past, there does not appear to be any systematic collection of data to support workforce planning as it relates to the availability of dental hygiene services.

Collecting Additional Practitioner Data On Dental Hygienists Would Improve Dental Workforce Planning

Without more detailed information on how many dental hygienists currently are practicing, where hygienists are working, and how many hours they are working, the overall effectiveness of dental workforce planning will be limited. A survey of dental hygienists would need to be conducted every two or three years to obtain current information that would be useful for workforce planning.

The issue of whether additional practitioner data are needed on Virginia nurses was studied by the Joint Commission on Health Care in response to House Joint Resolution 682 of the 1999 Session of the General Assembly. The HJR 682 report outlined a number of issues regarding what would need to occur to collect additional information on nurses. The same issues would need to be examined prior to collecting additional information on dental hygienists. These issues include: (i) identifying the data elements to be collected; (ii) developing a process for collecting the information, (iii) estimating the cost of collecting the information; and (iv) establishing a funding source other than existing license renewal fees to pay for the collection of additional information. (The Office of the Attorney General opined in 1995 that renewal fees cannot be used for purposes other than regulating the profession.)

Figure 3

Enrollment And Graduates At VCU/MCV Dental School 1989- 2000

Year	Enrollment	Graduates
1989	352	97
1990	339	85
1992	332	84
1994	310	79
1996	313	75
1998	316	75
2000[1]	316	76

Notes:
[1] Projected enrollment and graduates

Source: VCU/MCV Dental School

Virginia Commonwealth University's Medical College of Virginia Is The Only Dental School In The Commonwealth; The Number Of Dental School Graduates Has Declined Somewhat The Past Ten Years

Virginia Commonwealth University's Medical College of Virginia (VCU/MCV) is the only dental school in the Commonwealth. As illustrated in Figure 3, over the past 10 years, the enrollment at VCU/MCV has decreased from 352 to 316 students. Similarly, the number of graduates has decreased from 97 in 1989 to 76 (projected) in 2000.

While enrollments and the number of graduates have declined in the past 10 years, tuition and fees for dental students have doubled during the same time period. Figure 4 shows the increases in tuition and fees since 1989.

Figure 4

Tuition And Fees At VCU/MCV Dental School 1989- 2000

	Tuition and Fees [1]	
Year	**Va. Resident**	**Non-Resident**
1989	$5,703	$10,903
1990	$ 6,000	$11,450
1992	$ 8,997	$17,387
1994	$11,194	$20,984
1996	$11,953	$23,543
1998	$12,429	$24,821
2000[1]	$12,839	$25,948 [2]

Notes:
[1] Fees include university fees and instruments
[2] Instrument fee assumed to be same as 1999

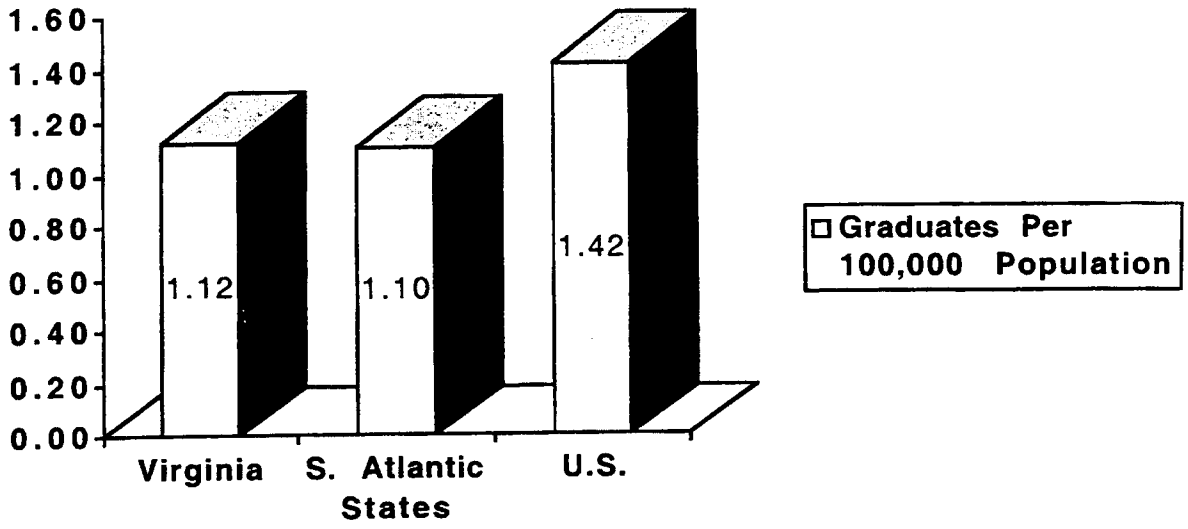
Source: VCU/MCV Dental School

The Annual Number Of Dental School Graduates At VCU/MCV Per 100,000 Population Is Slightly Higher Than That Of Neighboring States But Lower Than The Number Of Graduates Per 100,000 Population Nationwide

Based on information published by the American Dental Association (ADA), the number of dental school graduates at VCU/MCV is comparable to the number of graduates in neighboring states, but somewhat lower than the nation as a whole. As seen in Figure 5, the number of graduates per 100,000 population in Virginia is 1.12, whereas the number of graduates per 100,000 population for the South Atlantic states (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina and West Virginia) was 1.10. The number of graduates per 100,000 population across the U.S. was 1.42.

Figure 5

Number of Dental School Graduates Per 100,000 Population: Virginia, South Atlantic States, And The U.S. (1996)



Source: VCU/MCV, American Dental Association, Survey Center, 1996 *Distribution of Dentists in the U.S. By Region and State*

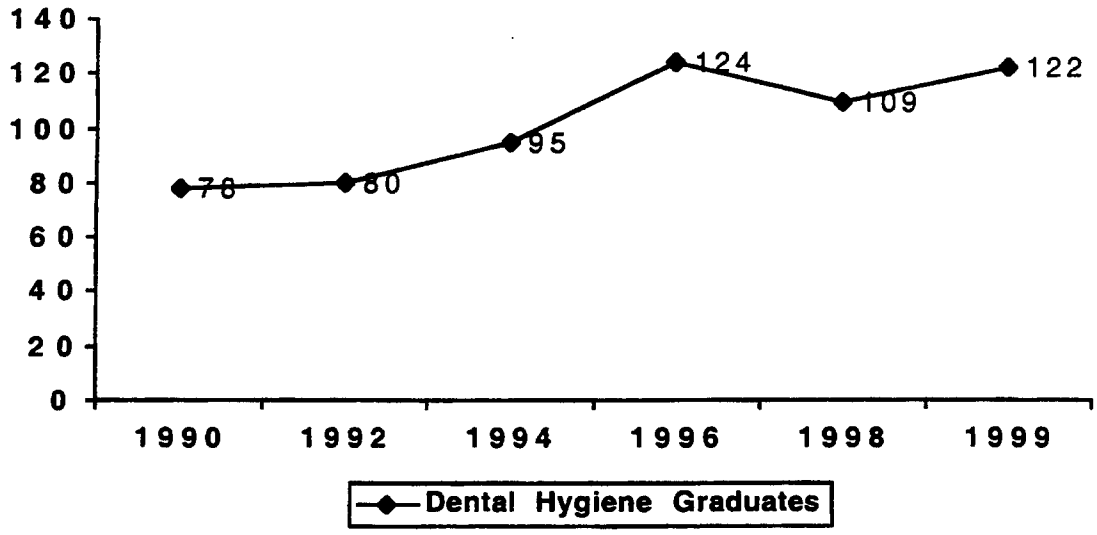
There Are Five Dental Hygiene Programs In Virginia; The Number Of Dental Hygiene Graduates Has Been Increasing During The Past 10 Years

The five dental hygiene programs in Virginia are: Old Dominion University (ODU), Virginia Commonwealth University/Medical College of Virginia (VCU/MCV), Northern Virginia Community College (NVCC), Virginia Western Community College (VWCC), and Wytheville Community College (WCC). The programs at ODU and VCU/MCV offer Baccalaureate Degrees in dental hygiene, whereas the community college programs offer associate degrees. ODU also offers a masters degree in dental hygiene.

The number of dental hygiene graduates in the past 10 years has increased substantially. Figure 6 illustrates the number of graduates since 1990.

Figure 6

Dental Hygiene Graduates In Virginia
1990 - 1999



Source: Dental Hygiene Programs

Figure 7 displays the number of graduates in each of the five dental hygiene programs for the 1999 academic year.

Distant Learning Programs Will Increase Further The Number Of Dental Hygiene Graduates

Two of the community college dental hygiene programs offer degrees through distant learning programs. NVCC sponsors a distant learning program in dental hygiene at Germanna Community College. VWCC sponsors two distant learning programs, one in Danville and the other at Lord Fairfax Community College in Winchester.

Figure 7

Dental Hygiene Graduates In Virginia
1999 Academic Year

Dental Hygiene Program	Number of Graduates
Old Dominion University	37
VCU/MCV	12
N. Va. Community College	25
Va. Western Community College	23[1]
Wytheville Community College	25
Total	122

Note
[1] Includes 6 graduates from Danville distant learning program
Source: Dental Hygiene Programs

The distant learning programs were instituted in recent years in response to a need for additional dental hygienists in these areas of the state. A study of the availability of dental hygienists was conducted pursuant to House Joint Resolution 81 in 1996. One of the subcommittee's recommendations was to develop additional dental hygiene educational programs in areas of the state where there was a shortage of hygienists.

The Danville distant learning program graduated its first students (6) in 1999. An additional 12 students have been admitted for the fall of 1999. The

Danville program expects to graduate 8-10 students every two years. The Germanna Community College distant learning program began in August, 1998. There have been no graduates as of yet; however, the program expects to graduate 10 students in August, 2000. The Lord Fairfax Community College distant learning program is not operational yet; it will begin in the fall of 2000. Once fully operational, the program expects to graduate 8-10 students every two years.

Assuming the number of graduates at the existing five dental hygiene programs remains at the 1999 level of 122, and the distant learning programs are producing an additional 8-10 graduates per year. The total number graduating each year will be approximately 132. In addition, VCU is considering expanding its program to graduate more students each year. Should this occur, the number of dental hygienists graduating each year will increase further.

Data Are Not Immediately Available To Compare Virginia's Annual Number Of Dental Hygiene Graduates To Other States

As previously noted, the amount of information collected on dental hygienists is quite limited in comparison to information on dentists. Data to compare the number of dental hygiene graduates per 100,000 population in Virginia to other states and the rest of the nation were not available at the time this report was written.

The Total Cost Of Tuition And Fees For In-State Dental Hygiene Students To Complete A Degree Program Ranges From Approximately $2,500 To $9,600 Depending On The Program And Type Of Degree

Depending on the program in which a dental hygienist enrolls, the total cost of tuition and fees to earn an associate degree at a community college is $6,500. The total cost (tuition and fees) of the dental hygiene coursework (2 years) required for a BS degree at VCU/MCV is $10,219 ($29,127 for out-of-state students). At ODU, the total cost (tuition and fees) of the dental hygiene coursework (2 years) required for a BS degree is $9,642 ($29,070 for out-of-state students).

IV.
Dental Care In Virginia

This section of the report describes the various programs and sources of dental care in Virginia. This section also identifies the underserved areas of the Commonwealth and the programs in place to attract additional dentists to these areas.

Nearly All Dental Services Are Paid For With Private Funds; Government Expenditures For Dental Care Are Minimal

The vast majority of dental care is provided in private dental practices. Based on national health expenditure data for 1997, a total of $50.6 billion was spent on dental care in the U.S. In both Virginia and the nation, dental care is paid for almost entirely with private funds (private insurance and out-of-pocket payments). Unlike overall health expenditures in which government programs paid for approximately 46% of the total, government programs paid for only 5% of total dental expenditures in 1997. Moreover, while 47% of dental services are paid "out-of-pocket," this same source of payment accounts for only 17% of all health expenditures and 16% of physician services. Figure 8 depicts these differences.

Nearly All Dentists Practice In 1 Or 2 Person Practices

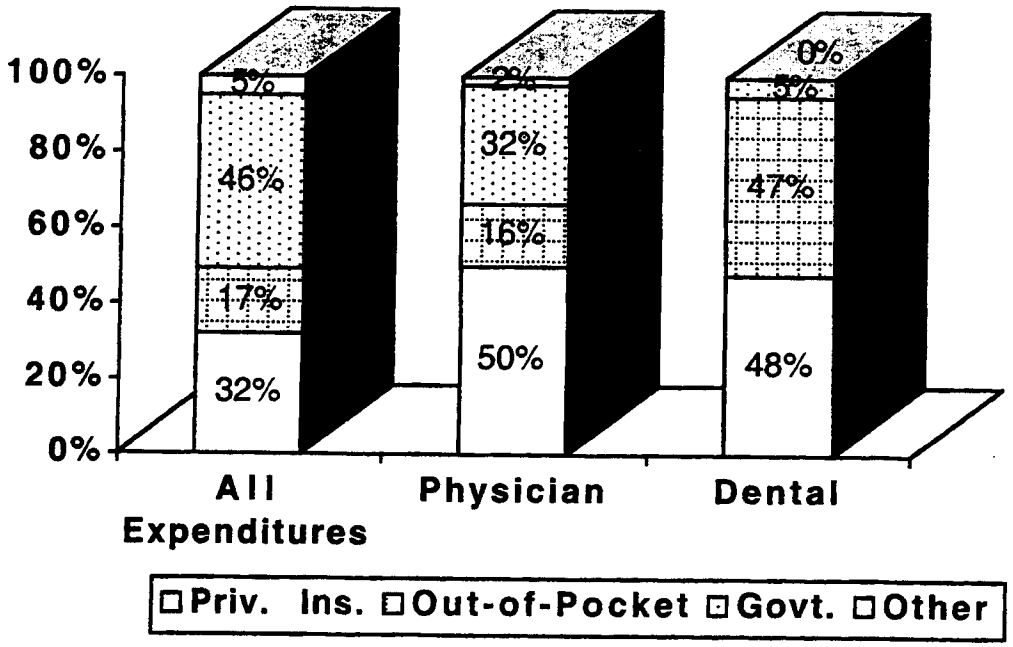
Another distinguishing characteristic of dentists is that a significant majority practice as solo-practitioners or in a 2 person practice. According to the American Dental Association, 90.6% of dentists are in 1 or 2 person practices compared to only 10.2% of physicians.

The Per Capita Amount Spent On Dental Care In Virginia Is Somewhat Lower Than The National Average

Data on per capita spending on dental care by individual states is included in the publication *1999 Health Care State Rankings*. Unfortunately, 1993 is the most recent data available. However, based on this information, the per capita expenditure for dental services in Virginia ($133) is somewhat lower than the national per capita rate of $145. Virginia ranked 26th among the 50 states in per capita spending for dental services.

Figure 8

1997 National Health Expenditures: Sources of Payment by Type of Service



Source: National Health Expenditures, 1997, HCFA

The Virginia Medicaid Program Provides Dental Services For Children Under Age 21; Dental Services Are Not Covered For Adults; The Virginia Children's Medical Security Insurance Plan (CMSIP) Also Provides Dental Services To Eligible Children

Since 1973, dental services have been covered for Medicaid children under age 21 through the Early and Periodic Screening, Diagnosis, and Testing (EPSDT) Program. Covered services include restorations, emergency relief for pain and elimination of infection, and preventative services and treatment such as x-rays, cleaning and fluoride treatments. Dental services are not covered under Medicaid for persons 21 and older. However, limited, medically-related dental services are covered for adults. The Virginia Children's Medical Security Insurance Plan (CMSIP) also provides the same level of dental services to eligible children. As of July, 1999, a total of 12,138 children are enrolled in the program.

Relatively Few Medicaid Children Actually Receive Dental Services Through Medicaid

Based on 1998 data from the Department of Medical Assistance Services (DMAS), a total of 370,249 children under age 21 were eligible for dental benefits. However, only 95,145 or 26% of eligible children actually received dental services through the Medicaid program. One of the key reasons for the high number of children not receiving dental services is the limited number of dentists participating in Medicaid (discussed later in this section).

DMAS data indicate that approximately $9.7 million was spent on dental services for children in fee-for-service programs in 1998 for an average cost of $131 per actual recipient or $36.87 per eligible child. (Cost data for children enrolled in the Medallion II capitated HMO program were not available.)

The Number Of Dentists Participating In Medicaid Has Been A Major Problem In Virginia And Throughout The Nation

As previously stated, the limited number of dentists participating in Medicaid is a key reason why so many children eligible for dental services have not actually received services. As seen in Figure 9, during the period 1989 - 1997, the number of dentists participating in Medicaid has declined.

A 1997 study of Medicaid dentists conducted by the Williamson Institute at Virginia Commonwealth University in response to Item 322(U) of the 1997 Appropriation Act found that 20 localities had no Medicaid participating dentists. A number of other localities were found to have too few dentists to provide appropriate access to dental care. Similar problems exist in other states.

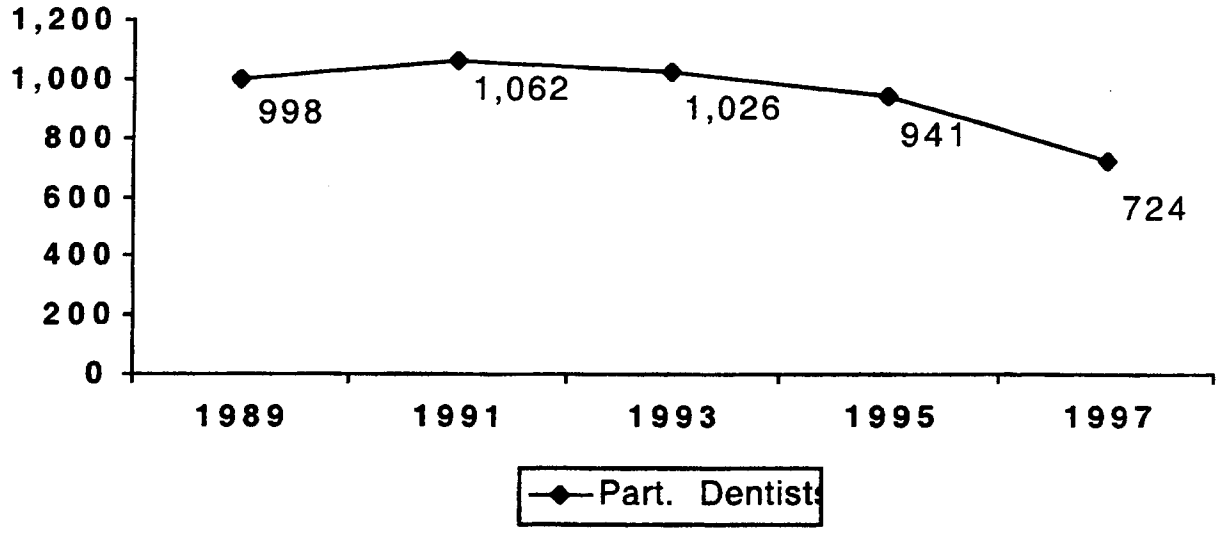
The Williamson Institute study found that the three main reasons dentists do not participate in Medicaid are: (i) inadequate reimbursement, (ii) broken appointments, and (iii) complex or excessive paperwork.

1998 Appropriations Act Directed DMAS To Work With The Department of Health And The Dental Community To Increase The Number of Dentists Participating In Medicaid; To Streamline Administrative Requirements; And To Remove Impediments To The Delivery of Dental Services

In response to the findings of the 1997 study conducted by the Williamson Institute, the 1998 General Assembly included language in the 1998 Appropriation Act directing DMAS to work with the Department of Health and the dental community to increase the number of dentists participating in Medicaid and to improve the administrative efficiency of the program.

Figure 9

Number of Dentists Participating In Virginia Medicaid Program 1989 - 1997



Source: The Statistical Record of the Virginia Medicaid Program, 1998

The 1998 budget submitted by Governor Allen included additional funding to increase the level of reimbursement for dental services. The General Assembly included additional funds to increase reimbursement rates to 85% of usual, customary, and reasonable (UCR) charges. However, the rates proposed by DMAS were based on fees originally adopted in 1991 by the Virginia Department of Health (VDH) and used by VDH in 1995 and as opposed to 85% of UCR charges. DMAS also included an inflation factor in arriving at the new rates. The DMAS proposed schedule would have set the rates closer to 65% of UCR.

The 1999 Appropriation Act Directs DMAS To Develop A Reimbursement Methodology Based On Commercial Insurer Data To Raise Dental Reimbursement To The 85th Percentile Of UCR Charges

In response to DMAS' proposed increase in dental fees, the 1999 General Assembly included language in the Appropriation Act to develop a methodology that would increase dental fees to the 85th percentile of UCR charges based on commercial insurers' data. DMAS is to report its revised methodology by September 1, 1999. The 1999 language also prohibits DMAS from requiring

dentists who agree to participate in the delivery of Medicaid services to pediatric dental patients to also deliver services to subscribers enrolled in the commercial plan of the managed care vendor.

DMAS has been working with the Virginia Dental Association (VDA) to develop the reimbursement methodology. Representatives of VDA and DMAS indicate that, thus far, progress is being made toward developing the new reimbursement methodology.

DMAS Has Taken Steps To Respond To Some Concerns Of The Dental Community

In response to the concerns voiced by the dental community regarding the Medicaid program, DMAS has taken several steps to begin to address these issues. In addition to working towards the revised reimbursement methodology, DMAS: (i) now accepts the ADA claim form for processing dental claims (although some additional data are still required); (ii) will send a letter to recipients after a second missed appointment to remind them of the importance of keeping dental appointments; (iii) has changed its HMO contracts in accordance with the 1999 Appropriation Act language regarding Medicaid dentists not having to accept other managed care patients from the commercial vendor, (iv) has changed the manner in which it reimburses for orthodontia services to pay over a shorter period of time, and (v) has offered to attend regional VDA meetings to provide information to dentists about Medicaid.

The VDA Has Taken Steps To Encourage Dentists To Participate In Medicaid

The VDA has actively participated in the work group established by DMAS to address the shortage of dentists participating in Medicaid. VDA also has communicated with its member dentists on several occasions encouraging them to participate in the program. Various newsletters have been sent to VDA members urging them to reconsider their past decisions not to participate in Medicaid, and to sign up for the program in response to the increased fees and other program improvements.

Most Recent Statistics Indicate An Increase In Dentists Participating In Medicaid

While Figure 9 illustrates a downward trend in the number of participating providers through calendar year 1997, DMAS' most recent statistics on dentist participation at the end of fiscal years 1998 and 1999 indicate that the number has increased. The number of participating dentists had increased to 802 as of July, 1998 and to 964 as of July, 1999. A substantial portion of this increase is due to

the dentists participating in the HMOs now enrolling Medicaid recipients as part of the expansion of the Medallion II program.

As DMAS continues to address the shortage of dentists participating in the Medicaid program, the Joint Commission on Health Care may wish to consider reviewing the revised reimbursement methodology, monitoring the implementation of the new rate schedule and other actions proposed to improve access to dental care in the Medicaid program.

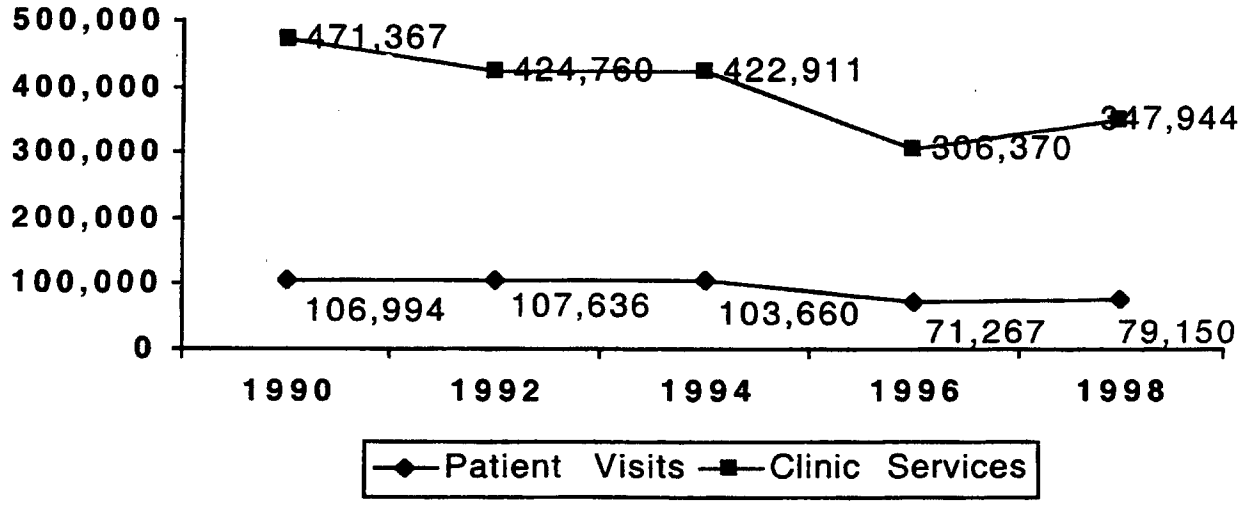
Dental Care Services Are Provided By Local Pubic Health Clinics In Approximately One-Half Of The Communities In Virginia

According to a report issued by the Virginia Department of Health in 1996, dental services are provided by local public health clinics to eligible individuals in approximately one-half of the communities in Virginia. Fifty-six communities are without a public health dental clinic.

Figure 10 illustrates the number of patient visits and total number of clinic services at the local public health clinics across the Commonwealth from 1990 through 1998. As seen in Figure 10, both patient visits and clinic services have declined 35% since 1990.

Figure 10

Number of Patient Visits And Clinic Services Provided In Public Health Clinics 1990 - 1998



Source: Virginia Department of Health

In FY 1998, approximately 50% of the services provided in local public health clinics were preventive in nature, 24% were diagnostic services, and the remaining 26% involved other types of services. The value of these dental services is estimated by VDH to be approximately $8 million.

VDH staff indicated that one likely reason why the number of dental services has declined is that the dental program is not a mandated service. Thus, if there are budget shortfalls in a public health clinic, dental care often is one of the services that is reduced to offset budget overruns in other areas. This is evidenced by the data in Figure 11 which indicate a total of $3.4 million in funding originally intended for dental services actually was spent on other types of services during FY 1996 – FY 1998.

Figure 11
Virginia Department of Health
Dental Health Services: Appropriations And Expenditures

Fiscal Year	Dental Appropriations (in millions)	Dental Expenditures (in millions)	Amt. Of Appropriation Spent On Other Services (in millions)
1996	$ 6.8	$ 5.1	$ 1.7
1997	$ 6.1	$ 5.3	$ 0.8
1998	$ 6.5	$ 5.6	$ 0.9
TOTAL	**$19.4**	**$16.0**	**$3.4**

Source: Virginia Department of Health

Another potential reason for the decreases in patient visits and clinic services is the difficulty in recruiting and retaining public health dentists. As shown in Figure 12, the number of public health dentists has steadily declined since 1990. By 2000, VDH staff project the number of public health FTEs to be at 49.5, a 50% reduction since 1990.

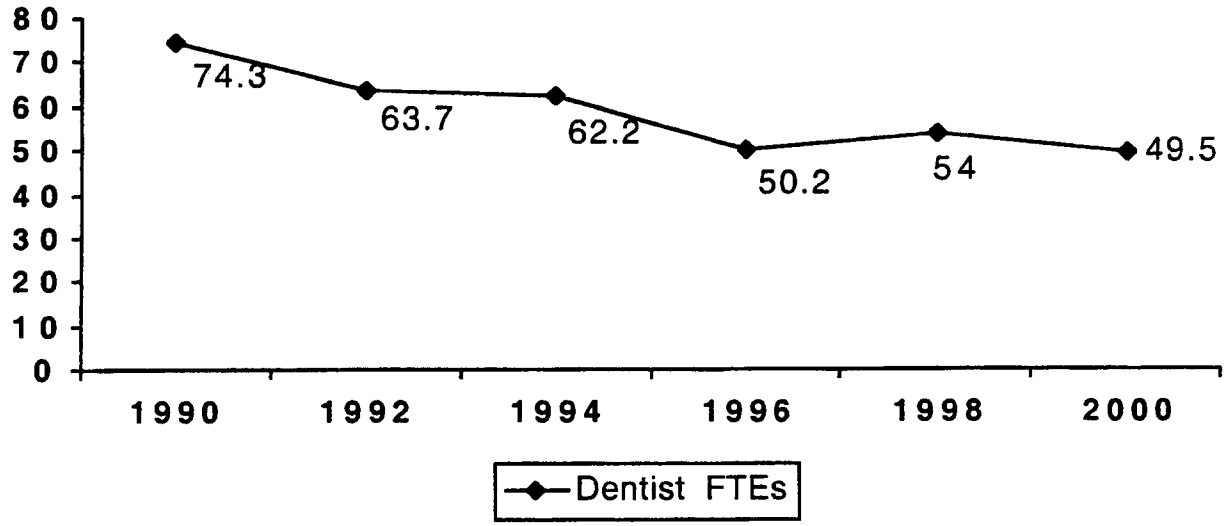
Public Health Dentists Earn Considerably Less Than Dentists In Private Practice

One likely explanation for the difficulty in retaining public health dentists is the relatively low salary they earn compared to dentists in private practice. There are two position classification grades; Public Health Dentist A and Public Health Dentist B. The Public Health Dentist A is a grade 16, the Public Health Dentist B classification is a grade 17. As seen in Figure 13, the salaries for these positions are far less than the average annual salary of a dentist in private practice.

Figure 12

Number of Dentist FTEs In Public Health Clinics

1990 - 2000



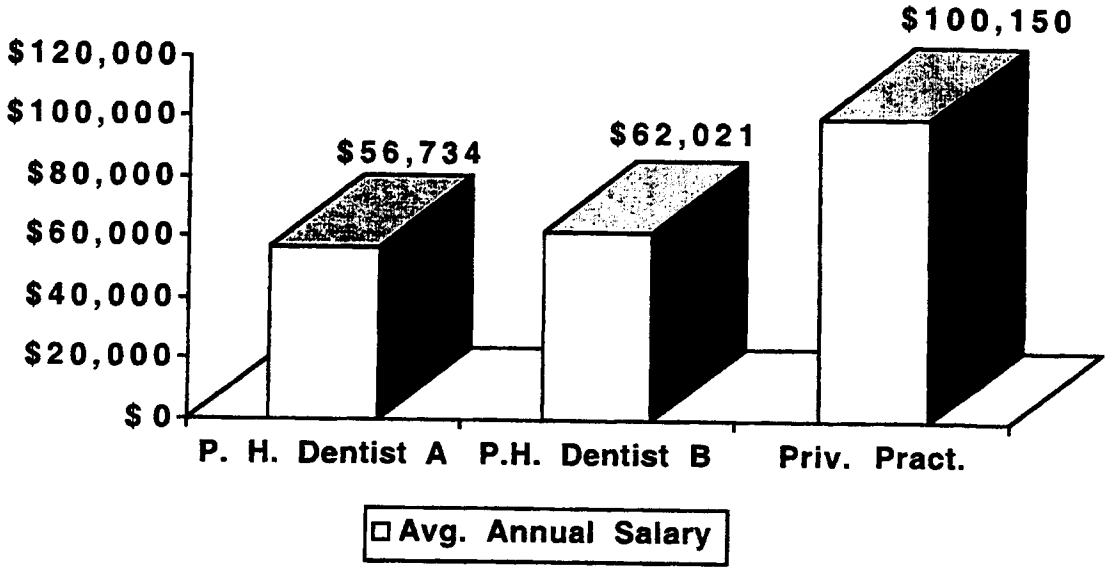
Source: Virginia Department of Health

Eighteen Free Clinics Provided Dental Care During 1998

In 1998, 18 of Virginia's 31 Free Clinics provided dental services to patients. While most of the Free Clinics are able to provide dental services only for a limited number of hours, a total of 7,038 patient visits were recorded in 1998 with the total value of services estimated to be $713,539. As seen in Figure 14, the number of patient visits, the value of dental services and the number of volunteer dentists increased substantially from 1997 to 1998.

Figure 13

Salary Comparison: Public Health Dentist A, Public Health Dentist B And Private Practitioners



Note: Salary for Public Health Dentist A reflects Grade 16, step 10, Public Health Dentist B, Grade 17, Step 10

Source: Virginia Department of Health, Virginia Employment Commission, *1997 Occupational Wage Data*

Figure 14

Dental Services Provided At Virginia's Free Clinics 1997 – 1998

Year	Dental Visits	Value of Dental Services	Volunteer Dentists
1997	4,764	$518,902	210
1998	7,038	$713,529	236

Source: Virginia Association of Free Clinics

Representatives of the Virginia Association of Free Clinics (VAFC) indicated that many of the services provided by the clinics are performed by dentists working in their private offices rather than in the Free Clinic itself. More free clinics would like to provide dental services, however, the cost of equipping an office and the difficulty in finding volunteer dentists limit their capabilities. Those clinics that do provide dental care report persistent waiting lists for persons in need of care. Many of the patients that are seen do not receive regular care, often have abscessed teeth, and are in need of extensive treatment.

Approximately One-Fourth Of The 43 Community And Migrant Health Centers Have Dental Programs; Several Others Arrange With Other Providers To Deliver Dental Care

Approximately one-fourth of the 43 Community and Migrant Health Centers throughout Virginia offer dental services through the center's providers. In addition, several others arrange for dental services to be provided by other practitioners outside of the center. The Virginia Primary Care Association indicates that increasing the number of centers that provide dental services is a priority. As with the Free Clinics, the availability of dentists to work at the centers is a continuing problem. New federal funding for community and migrant health centers, estimated to be $100 million, was authorized last year. While there is no specific amount of the funding set aside for dental programs, a portion could be used to support additional dental services.

The Virginia Health Care Foundation Has Provided $1.6 Million In Grants To Improve Access To Dental Care

Since 1994, the Virginia Health Care Foundation (VHCF) has approved a total of 16 grants to organizations across the Commonwealth to improve access to dental care. These grants amounted to approximately $1.6 million. The VHCF anticipates providing an additional $306,800 in grant funds for current grantees.

Healthy Communities Loan Fund: In addition to the dental-related grants, the VHCF also has established the Healthy Communities Loan Fund. This fund provides low interest rates through First Virginia Banks, Inc. to help primary health care professionals, including dentists, establish practices in underserved communities. The terms of the loan are individually tailored for each applicant and amounts typically range from $50,000 - $250,000. Additionally, there are no bank fees and no points.

Providers who qualify for a loan can use the funds to: (i) provide working capital to develop new practices or to expand an existing practice; (ii) renovate existing facilities or buy new equipment; (iii) fund conversions of practices to

rural health clinics; (iv) finance elements of a recruiting package to bring a new provider to the area; or (v) underwrite other similar initiatives.

The VHCF reports that four loans to dentists have been closed. An additional six loans have been approved by the VHCF's loan advisory group, but have not yet been closed.

Other VHCF Programs: The VHCF also has sponsored "Tooth Talk." This program provided information on: (i) various dental programs in Virginia; (ii) successful dental models; (iii) sources of assistance to dental programs; (iv) dental "best practices;" and (v) patient education materials. The VHCF also has sponsored a program entitled "Models That Made It," which provides information on replicating successful health care model programs in other communities. The goal of each of these programs is to expand access to dental care in underserved areas. As noted below, the VHCF also provides financial support to the Donated Dental Services (DDS) program.

The Virginia Dental Association Sponsors The "Donated Dental Services" Program As A Means Of Providing Care To Underserved Populations

The Virginia Dental Association (VDA) sponsors the "Donated Dental Services" (DDS) program to help indigent and elderly persons by matching them with volunteer dentists. In addition to volunteer dentists, dental laboratories also donate services for crowns, bridges, and dentures. In Virginia, the Virginia Health Care Foundation, the Annabella R. Jenkins Foundation and the VDA provide funding for the program.

Since October of 1997, a total of 153 cases have been completed, with an additional 120 patients currently receiving treatment. Many of the cases involve extensive treatment. Patients who receive DDS services are not eligible for Medicaid and are not receiving services from the Free Clinics. Many of the patients are elderly persons or persons with disabilities. As such, the DDS program focuses on truly underserved populations.

A total of 367 dentists and specialists along with 63 laboratories have volunteered for the program. The total monetary value of the services provided through the DDS Program was $285,639. Of this amount, the dentists' contributions were $261,685 and the contributions of the laboratories were $24,954. As of April, 1999, there was a list of 708 persons waiting to receive services through the program.

While Various Programs And Significant Resources Are Provided For Dental Care In Virginia, The 1996 Health Access Survey Found That Many Virginians Have Not Seen A Dentist For An Extended Period of Time

In 1996, the Virginia Health Care Foundation sponsored a health access survey which included questions on access to dental care. The survey found 11% of respondents reported not having seen a dentist in over four years. Moreover, 6% of respondents indicated that they have never seen a dentist. These statistics indicate that a significant number of Virginians are receiving inadequate or no dental care. One of the major reasons for this is the limited number of dentists practicing in many communities across the Commonwealth.

While The Ratio Of Dentists To Population In Virginia Is Comparable To The Nation As A Whole, There Are Many Underserved Communities

A number of different statistics have been calculated to measure the number of dentists practicing in Virginia. These statistics produce varying results based on how the number of dentists is counted, the year in which the data was collected, and the source of the data.

Information regarding the number of actively practicing dentists provided by the Board of Dentistry indicates that Virginia has approximately 56.4 dentists per 100,000 population. Information collected by the American Dental Association (ADA) on the number of active practitioners indicates that there are 58 dentists per 100,000 population in the U.S. Although Virginia's statewide ratio of dentists to population compares favorably to national statistics, in many communities across the Commonwealth, the ratio of dentists to population is significantly lower.

The Virginia Department of Health Concluded In 1996 That While The Overall Dentist To Population Ratio In Virginia Is Favorable, There Are A Number Of Underserved Areas

The Virginia Department of Health (VDH) conducted a study on the availability of dental services in 1996 in response to Item 311 of the 1996 Appropriation Act. VDH found that while the overall ratio of dentists to population (1 dentist per 2,002 persons) in Virginia is favorable, there are significant disparities in communities across the Commonwealth.

VDH identified "underserved" areas to be those communities which have a ratio of 1 dentist to 5,000 persons or higher. This ratio is the same as one of the main indicators used by the National Health Services Corps Loan Repayment

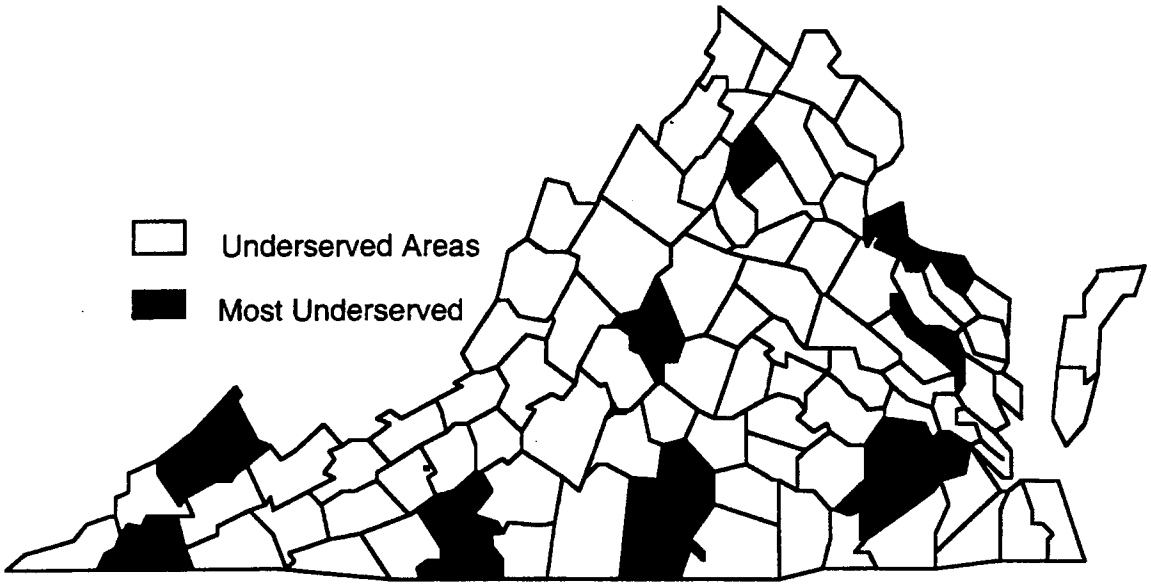
program to designate a dental health professional shortage area (HPSA). VDH identified 43 communities with dentist to population ratios higher than 1 to 5,000. In addition to these communities, VDH identified 15 communities as the most underserved areas of the state based on high dentist to population ratios, limited public health dentists, and few Medicaid providers. The 43 underserved areas and the 15 "most underserved" areas are identified in Figure 15.

The Underserved Areas Identified By The Virginia Department Of Health Are Not Based On The Same Criteria Used By The National Health Services Corps Loan Repayment Program

While VDH identified dental underserved areas in its 1996 study, the criteria used to identify these underserved areas are not entirely the same criteria as that used by the National Health Services Corps (NHSC) for its student loan repayment program. The criteria for the NHSC program are far more extensive and involve factors other than a dentist to population ratio.

Figure 15

Virginia's Dental Underserved Areas



Source: Virginia Department of Health, Item 311 Final Report

The NHSC loan repayment program is sponsored by the U.S. Department of Health & Human Services and provides significant loan repayment amounts to physicians, dentists and mental health workers and other health professionals in return for agreeing to practice in a health professional shortage area (HPSA). Health providers who agree to locate in a HPSA are eligible for up to $50,000 for a 2-year commitment, up to $85,000 for a 3-year commitment, and up to $120,000 for a 4-year commitment.

The loan repayment amounts provide a significant incentive for a dentist to locate in an underserved area. However, to obtain the loan repayment, the dentist must locate in an underserved area that is designated as a dental HPSA. In addition to the loan repayment program, communities designated as HPSAs also are eligible for additional benefits, including the following:

- Institutions that place providers in HPSAs can receive grants from Title X Family Planning Services Training Program;
- Physicians locating in non-metropolitan HPSAs are exempt from new Medicare limitations on "customary charges;"
- Public Health Service Grant Programs give funding preference to Title VII and Title VIII training programs in HPSAs; and
- The National Health Services Corps Scholarship Program provides scholarship funds to health professionals who locate in HPSAs.

Despite the benefits that can be gained through HPSA designations, in Virginia, there is no state agency or other entity responsible for collecting, analyzing, and submitting the information required for a HPSA designation. VDH has recently begun to perform this function. However, despite the fact that 43 areas in Virginia meet at least one criterion (1 dentist per 5,000 population) for HPSA designation, only 10 communities in Virginia currently are designated as dental HPSAs. These areas are: the counties of Accomack/Northampton, Brunswick, Buchanan, Dickenson, Lee, and Russell, portions of Nelson County, portions of Newport News, portions of Richmond City, and portions of Suffolk City. VDH indicates that limited staffing within the agency is the primary reason why other areas have not been designated as dental HPSAs.

While the *Code of Virginia* does not require VDH to obtain designations for underserved areas, this task is closely related to the overall function of the Office of Policy and Primary Care and Rural Health within the agency. Designating areas as HPSAs has application not only to this review of dental services but also the overall health workforce programs being reviewed by the Joint Commission in response to study language included in the 1999 Appropriation Act.

The Virginia Dental Scholarship Program Provides Scholarship Money For Students Who Agree To Practice In Underserved Areas; However, Few Students Are Accepting The Scholarships

The Virginia Dental Scholarship Program is administered by VDH and provides scholarship money to students who agree to practice in underserved areas. Prior to 1999, ten scholarships of $2,500 each were available each year for Virginia dental students who agreed to provide one year of service in a Virginia underserved dental area for each year of scholarship award. The 1999 Appropriation Act increased the amount of the scholarships to $5,000 each, but reduced the number of scholarships to five.

VDH staff indicated that prior to 1994 when a number of changes in the terms of the scholarship were instituted, most, if not all, of the scholarships were awarded each year. However, since 1994, only 1 or 2 scholarships have been awarded each year.

VDH indicates that the primary reasons why the number of recipients has declined are: (i) the small amount of the scholarship amount ($2,500 prior to 1999); the "triple-payback" provision for students who do not complete the service requirement; and (iii) the contract provision which requires the recipient to treat all patients regardless of ability to pay.

While the amount of the scholarship has increased to $5,000, this amount is still less than one-half the cost of a year's in-state tuition at VCU/MCV dental school. Moreover, the number of scholarships has been reduced to only five. These amounts are quite low compared to the medical scholarship program in which 67 scholarships of $10,000 ($5,000 general fund/$5,000 Virginia medical school) each are awarded each year.

The provision regarding treatment of all patients regardless of ability to pay also appears in the medical scholarship contract. However, VDH indicates that because Medicaid and Medicare coverage of dental services is so limited, the number of individuals without any financial support for dental care is substantially greater than the number of such persons seeking medical care. Consequently, this provision places a greater financial burden on dental students than medical students. (Figure 8 illustrates the high percentage of "out-of-pocket" payments for dental care.)

The Number Of Dental Hygienists Per 100,000 Population In Virginia Is Lower Than That For The Nation

Information provided by the Board of Dentistry indicates that there are approximately 35 active dental hygienists per 100,000 population in Virginia. Based on data from the American Dental Hygienists Association, the national ratio is 46 hygienists per 100,000 population.

The availability of dental hygienists was studied by a legislative subcommittee in response to HJR 81 of the 1996 Session of the General Assembly. One of the subcommittee recommendations was to fund the Virginia Community College System to provide "distant learning programs" for dental hygienists. As discussed earlier in this report, these programs are now becoming operational and will be increasing the number of graduates. As these additional graduates enter the workforce, the ratio of hygienists to population should increase.

The Dental Hygienist Scholarship Program Was Established To Recruit Hygienists To Underserved Areas; However The Program Has Never Been Funded

A dental hygienist scholarship program was established in 1994 as a means of recruiting hygienists to underserved communities. Section 32.1-122.10 of the *Code of Virginia* establishes the scholarship program; however, funds have never been appropriated. The *Code of Virginia* provisions are similar to those of other scholarship programs and require that recipients practice in an underserved area. The *Code of Virginia* requires the Board of Health to promulgate regulations to implement the scholarship program. While the program was established in 1994, to date, the regulations have not been promulgated.

V.
Improving Access To Dental Care In Virginia

The central focus of House Joint Resolution (HJR) 644 is to find ways of increasing access to dental care throughout the Commonwealth. This section of the report identifies various actions that could be taken to improve access based on numerous JCHC staff interviews, the actions of other states, and issues found in the literature regarding dental care.

Designating Dental Health Professional Shortage Areas Is A Fundamental And Critical Function That Must Occur On A Continuing Basis In The Commonwealth

As previously discussed, the National Health Services Corp Loan Repayment Program provides significant financial support to dentists in return for locating in an underserved area. Areas must be designated as a dental health professional shortage area (HPSA) in order for a dentist to obtain this benefit. While the Virginia Department of Health (VDH) has begun to conduct the analyses necessary to get the dental HPSA designations, a more formalized and structured approach is needed to ensure that the appropriate areas are designated and that the designations are kept current.

Currently there is no *Code of Virginia* requirement that the VDH perform this function. However, due to the complexity of the analyses required, the expertise that is required, and the current role of VDH in overall health workforce planning, consideration should be given to amending the *Code of Virginia* to require VDH to conduct and maintain these designations. These designations would include not only dental HPSAs but medical and mental health HPSAs as well. If this responsibility is required of VDH, additional staff resources likely would be needed.

Efforts To Increase The Number Of Dentists Participating In Medicaid Appear To Be Moving Forward, The Progress Of These Efforts Needs To Be Monitored

Representatives of both DMAS and the VDA indicate that, at the present time, there appears to be progress being made in revising the Medicaid fee schedule to increase reimbursement for dentists, and in addressing other concerns regarding participation in the program. DMAS is required to report its revised methodology to the Governor and the General Assembly by September 1, 1999. There also is language in the Appropriation Act (Item 335 (R)) requiring

DMAS and VDH to work with representatives of the dental community to enhance the Medicaid dental program. This language requires that the agencies annually report their progress by December 15th of each year.

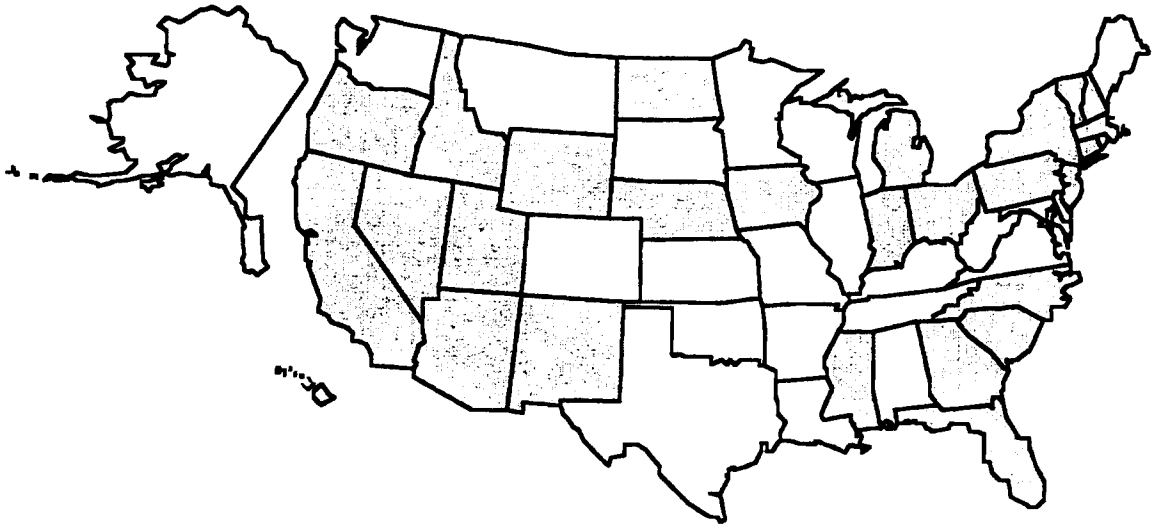
Efforts to increase the number of dentists participating in Medicaid, improve the administration of the program, and enhance the delivery of services need to be monitored to ensure that improvements are indeed realized. Depending on the actual results, the Joint Commission may wish to consider taking additional actions in this area.

At Least 27 States Provide Dental Benefits To All Medicaid Eligibles; Virginia Could Extend Some Level Of Dental Benefits To Adult Medicaid Eligibles

The Virginia Medicaid program provides dental benefits only to children under age 21. According to the American Dental Association (ADA), at least 27 other states provide dental benefits to all Medicaid eligibles. Figure 16 identifies these states.

Figure 16

States That Provide Dental Benefits To Adult Medicaid Eligibles (1997)



Source: American Dental Association, 1997

Cost of Expanded Medicaid Coverage Would Be Substantial: Extending dental benefits to adult Medicaid eligibles would increase significantly the cost of

the Medicaid program. The additional costs would depend on the type of covered services, the utilization of services, the level of reimbursement, the number of covered adults and the delivery system for providing the benefits. Staff at DMAS indicated a comprehensive actuarial analysis would be necessary to develop an accurate estimate of the additional costs. Such an analysis could not be completed in time for this report.

To obtain at least some idea about the cost of extending Medicaid coverage to adults, a rough cost estimate was calculated based on the dental claims paid per eligible Medicaid adult in other states included in a 1998 ADA report. Fiscal year 1997 data for both claims and eligible adults for 13 states were analyzed. In these 13 states, an average of $81.74 was paid in dental claims per covered adult. Based on the average cost per adult in other states, a rough approximation of the total cost to extend dental benefits to the 326,484 adults in the Virginia Medicaid program would be approximately $26.7 million or $12.9 million GF per year.

Again, this is a rough approximation of the additional cost to provide dental benefits to adults. The actual amount could vary substantially from this estimate. Moreover, the cost may be higher in the first one or two years than the above estimate inasmuch as there may be a greater demand for services due to adults not having received needed dental care in the past. As noted by DMAS, a comprehensive actuarial analysis would be needed to base any potential future appropriations.

Continuing increases in the number of Medicaid dentists would be needed to handle the additional number of persons receiving dental benefits.

The Commonwealth Could Increase The Number And Amount Of The Dental Scholarships; Consideration Should Be Given To Revising The Requirement That Recipients Treat All Patients Regardless Of Ability To Pay

While the amount of the dental scholarships has been increased from $2,500 to $5,000, the current amount still represents only about one-half of an in-state student's tuition at VCU/MCV dental school. Moreover, while the amount per scholarship increased, the number of scholarships is now only 5 each year. In light of the fact that 43 communities have dentist to population ratios of 1:5,000 or greater, an increase in the number and amount of the scholarships would increase the likelihood of new graduates locating their practices in these localities. Increasing the scholarship amount to $10,000 would approximate a year's tuition for an in-state student.

In addition to increasing the amount and number of the scholarships, consideration should be given to revising the requirement in the contract that

dentists treat all patients regardless of ability to pay. While this provision certainly is well-intentioned, VDH staff believe the large number of persons without ability to pay for dental care makes the scholarship significantly less attractive to dental students. Consideration should also be given to having VDH use the same dental heath professional shortage areas designated for the National Health Services Corps Loan Repayment Program so that there is one common set of criteria that all programs utilize.

A Virginia Dentist Loan Repayment Program Could Be Implemented To Supplement The Scholarship Program

Experts in the field of health workforce recruitment and retention agree that loan repayment generally is more effective than scholarships for attracting health professionals to underserved areas. The primary reason is that at the time a student accepts a scholarship, he/she could be several years away from actually establishing a practice. Because a student's situation can change in many respects during this period of time, many are reluctant to commit to the service requirement so early. However, a decision to accept a loan repayment contract generally is made just prior to, or after graduation. At this time, the student is more certain of his/her immediate plans and is better able to decide whether to accept the associated service requirement.

A loan repayment program could be implemented with the same service requirements established for the scholarship program. Another alternative suggested by a dentist interviewed during the study would provide loan repayment not only for a dentist who agrees to practice in an underserved area, but also for dentists who agree to provide services to underserved populations (e.g., indigent patients). Under the alternative scenario, additional administrative paperwork likely would be necessary on the part of the dentist to document the number of indigent patients served; however, such an approach could prove effective in expanding access to care for specific underserved populations. Like the scholarship program, the amount of the loan repayment program could also be set at $10,000 for each year of service requirement.

The Dental Hygiene Scholarship Program Could Be Funded To Attract Dental Hygienists To Underserved Areas

Established in 1994, the dental hygiene scholarship program has never been funded. Providing funds for these scholarships would help attract dental hygienists to underserved areas of the Commonwealth. As suggested above for the dental scholarships, consideration should be given to setting the amount of the scholarship to the level of a year's tuition. Even if funding is not approved for the program, the Board of Health should promulgate regulations for the

program so that if funding is eventually provided, there would be no delay in awarding the scholarships.

Consideration Should Be Given To Increasing The Salaries Of Public Health Dentists

The current salaries of Public Health Dentists A (grade16) and Public Health Dentists B (grade 17) are far below the average salaries of dentists in private practice. The disparity in salaries between public health and private dentists is considered to be a major reason why the number of public health dentists has been declining steadily since 1990.

Consideration Should Be Given To Directing The Virginia Department of Health To Report To The Governor And The General Assembly On: Actions That The Agency Will Take To Ensure That Appropriated Funds Are Spent On Dental Services, And The Feasibility Of Extending Public Health Dental Services To Those Communities Without Such Services

A total of $3.4 million of the funds appropriated for dental care was spent on other services during the past three fiscal years. This practice obviously reduces the amount of dental care provided in public health clinics. Consideration should be given to requiring VDH to report to the Governor and the General Assembly on ways to ensure that the funds are, in fact, used to provide dental care.

As previously noted, public health dental services are not provided in 56 communities in Virginia. VDH could be directed to study the feasibility and cost of extending public health dental services to these Communities.

The Condition And Use Of "Dental Trailers" Should Be Reviewed

Much of the public health dental services are provided in "dental trailers." These units are equipped to provide basic dental services. While no hard evidence was obtained during the course of this study regarding the condition and utilization of the trailers, anecdotal evidence suggests that some of the trailers may have become outdated and others may not be used to their full potential. The Joint Commission may want to request VDH to review the condition and use of the trailers and report its findings to the Governor and the General Assembly.

Providing An Opportunity For Dental Students To Participate In A Preceptor Or Externship Program In An Underserved Community As Part Of Their Dental Training Should Be Considered

Exposing health professions students to practicing in an underserved area as part of their training has been successful in identifying students who may want to practice in these areas after graduation. Currently, the dental school curriculum does not include such a program. However, the dean of the VCU/MCV dental school indicated to JCHC staff that he is very interested in a program that would provide students with perhaps two rotations of two weeks each in their fourth year of training. The dean has formed an Outreach Planning Group within the dental school to begin examining the possibility of instituting such a program.

To implement the program, funding likely would be needed to support faculty supervision of the students and other associated expenses. Consideration should be given to introducing a resolution expressing support for such a program and requesting VCU/MCV to develop and present a plan to the Governor and the General Assembly for implementing the outreach program.

Consideration Should Be Given To Allowing "Licensure By Endorsement" For Dentists Who Agree To Practice In An Underserved Area For A Given Period Of Time Or Provide Services At A Public Health Clinic, Community Health Center Or Free Clinic

The *Code of Virginia* does not permit "licensure by endorsement" for dentists. According to a 1999 report by the Joint Legislative Audit and Review Commission (JLARC), dentistry is the only health profession in Virginia which does not permit licensure by endorsement. JLARC noted in its report published as 1999 House Document 31 that "the lack of a licensure by endorsement process does not appear to be related to protection of the public and appears to create a barrier to entry for out-of-state dentists." JLARC further reported that, based on interviews with board members and staff, there does not appear to be any factors related to public protection that would justify this difference in treatment for dentists.

In 1995, the Board of Dentistry promulgated regulations establishing licensure by endorsement beginning in April, 1995. Legislation was subsequently enacted which became effective July 1, 1995 that eliminated licensure by endorsement. JLARC reported that for the three month period when licensure by endorsement was available, the Board received 533 applications from dentists in other states.

The Virginia Dental Association (VDA) is opposed to allowing licensure by endorsement. VDA representatives indicated that they have concerns about the tests that are administered in other states and the qualifications of dentists that would be allowed to practice in Virginia under such a provision. VDA also noted that, if allowed, few dentists licensed by endorsement would locate in an underserved area.

There clearly are no assurances that if Virginia allowed licensure by endorsement the new dentists would locate in underserved areas to improve access to care. However, licensure by endorsement could be offered only to those dentists who agree to: (i) practice a certain percentage of time in an underserved area for a given period of time (e.g., two years), (ii) donate a certain amount of services at a Free Clinic, or (iii) provide a certain amount of services at a Community Health Center or a public health clinic. In this way, there would be some incentive for dentists from other states wanting to practice in Virginia to do so in an underserved area.

34 States And D.C. Permit Licensure By Endorsement: The American Dental Association (ADA) reports that 34 states and the District of Columbia grant licensure by endorsement to dentists who have been practicing for a period of time in other states. Figure 17 identifies these states.

Consideration Should Be Given To Allowing Dental Hygienists To Perform Some Services In Certain Settings Without Direct Supervision By A Dentist

Current Virginia law and regulations require dental hygienists to perform all services under the direct supervision of a dentist. This means that no dental hygiene services can be provided to patients without the dentist being present. Allowing dental hygienists to provide basic services such as cleanings and dental sealants in officially designated underserved areas, or certain settings such as public health clinics, Free Clinics, Community Health Centers, and public schools could expand access to these basic, preventive dental services.

As contemplated here, allowing dental hygienists to perform certain services without direct supervision would <u>not</u> involve: (i) expanding the hygienist's scope of practice, (ii) establishing a practice independent of a dentist, or (iii) obtaining direct reimbursement from insurers. Rather, the hygienist would be providing basic preventive care under a less restrictive level of supervision. Representatives of Free Clinics, Community Health Centers, public health clinics and others have suggested this as a way of making these services more available in areas of the state where there are too few dentists and/or in settings (e.g., public schools or mobile clinics) where it is difficult for a dentist to get to all of the patients. While some also have suggested nursing homes as a

potential setting, the Virginia Health Care Association indicated that access to dental care in their facilities has not been a problem.

Under this scenario, the dental hygienist would still be practicing as part of a dentist's office, would still bill through the dentist, and would refer patients needing further treatments to the dentist. Regulations could also be adopted to require that the dentist approve a specific treatment plan for the patient and "prescribe" the services to be delivered by the hygienist. Further, if desired, provisions could be included limiting this level of supervision to only those hygienists with a certain level of education, or a minimum number of years of experience.

Figure 17

States That Allow "Licensure By Endorsement" For Dentists

States That Permit Licensure By Endorsement

Source: American Dental Association, 1999

VDA Opposes Less Restrictive Supervision Requirements: The VDA has indicated that it strongly opposes any attempt to make the present supervision requirements for dental hygienists less restrictive. VDA representatives expressed concern for the level of care that would be provided without direct supervision by the dentist. The VDA concerns include the following: (i) hygienists are not trained to perform all procedures involved in total patient care

and their training is predicated on supervision by a dentist; (ii) hygienists are not educated in pharmacology and cannot prescribe medications; therefore, they cannot provide appropriate treatment to medically compromised patients or manage rare medical emergencies; (iii) the functions hygienists are qualified to perform cannot be separated from total patient care and should not be offered piecemeal; (iv) without dentist supervision, patients may incorrectly believe that critical diagnosis and treatment planning services were rendered when, in fact, only a dentist is qualified to perform these services; and (v) the same barriers that exist for dentists to practice in underserved areas also exist for dental hygienists.

VDA argues that reducing the level of supervision will not improve access to care for underserved populations or in underserved areas. Further, VDA noted that in three states where less restrictive supervision is permitted, few hygienists actually provide services in the practice settings in which there is less supervision.

Most States Allow Less-Restrictive Supervision In Certain Settings: There are essentially three levels of dental hygiene supervision. There are varying definitions of these three levels of supervision. The American Dental Association uses the following definitions: (i) direct supervision means the dentist is in the office and evaluates the patient during the same visit; (ii) indirect supervision means the dentist is in the office but may evaluate the patient at a later time; (iii) general supervision means the dentist has authorized the procedure but is not necessarily in the office.

According to a 1995 survey published by the ADA, Virginia is one of only 7 states in the nation that require only direct supervision in all practice settings (i.e., dental office, school systems, long-term care facilities, state/institutional clinics, home bound persons). The other six states are Georgia, Kansas, Kentucky, Mississippi, Oklahoma and West Virginia. Figure 18 illustrates the supervision requirements in place across the country.

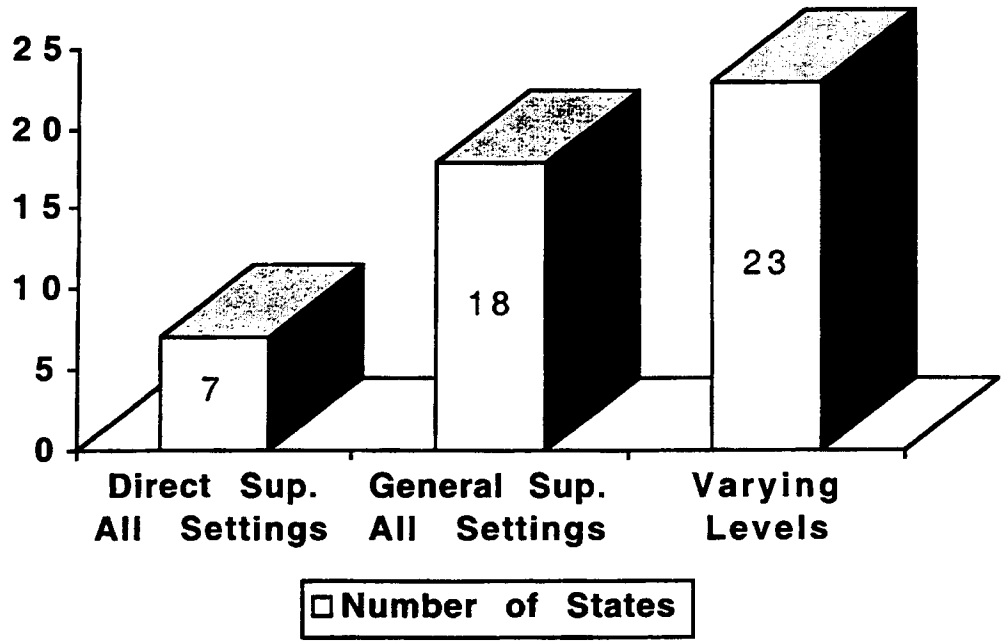
The American Dental Hygienists Association (ADHA) has published information that indicates 35 states allow dental hygienists to provide oral prophylaxis (cleanings) without the presence of the dentist in private practice settings. Information from the ADHA also indicates that 45 states permit dental hygienists to perform certain functions without the physical presence of a dentist being required.

States Have Varying Regulatory Provisions Regarding Supervision: Depending on the level of supervision permitted, states have varying regulatory provisions regarding supervision of dental hygienists. Also, states have enacted varying definitions of the terms "direct," "indirect" and "general" supervision.

Some states limit the locations in which hygienists can work under general supervision (e.g., Delaware permits this in the dentist's office, public school or other institution). Some states, such as Massachusetts, identify a level of supervision for each type of service provided by a hygienist; while others (e.g. Maine) identify the specific tasks that can be provided under general supervision. Some states (e.g., Connecticut) also specifically require that hygienists refer any patient with needs outside the hygienist's scope of practice to the dentist for treatment. Lastly, some states allow general supervision only for dental hygienists who have a minimum number of years of experience.

Figure 18

Dental Hygiene Supervision Requirements



Note: - Three states did not provide responsive or complete information to ADA survey
- Two of the 18 states shown with general supervision in all settings require no supervision in school systems
- States shown with varying levels of supervision require different levels in various settings

Source: American Dental Association, 1995

The Joint Commission on Health Care May Wish To Consider Continuing This Study To Examine More Closely Ways To Increase The Number Of Persons With Dental Insurance

Given the breadth of the study directive of HJR 644, this study was not able to include a comprehensive analysis of ways to increase the number of persons with dental insurance. Research has consistently shown that persons with insurance have greater access to health care services. However, this issue requires an in-depth analysis unto itself. As such, the Joint Commission may want to consider continuing this study next year to examine the issue of increasing the number of persons with dental insurance.

VI.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue.

Option I **Take No Action**

Option II **Introduce Legislation Providing The Virginia Department Of Health With Responsibility For Designating Virginia Communities As Dental, Medical, And Mental Health Professional Shortage Areas, And For Maintaining These Designations**

This legislation would need to be coordinated with any potential legislation emanating from the Health Workforce Study being conducted pursuant to the 1999 Appropriation Act. Depending on the actions taken as a result of that study, an accompanying budget amendment likely would be needed to provide additional staff (perhaps 2 FTEs) to assume this responsibility. (The amount of the budget amendment will be determined later.)

Option III **Introduce A Budget Amendment To Increase The Number Of Dental Scholarships To 10 And To Increase The Amount Of The Scholarships To $10,000 Each ($75,000 GF)**

Option IV **Introduce Legislation To Revise The Dental Scholarship Requirement That The Recipient Treat All Patients Regardless Of Ability To Pay; Contract Could Be Revised To Require The Dentist To Participate In Medicaid, Volunteer A Given Number Of Hours At A Free Clinic, Or Provide A Given Level Of Services At A Community Health Center Or Public Health Center**

Option V **Introduce A Budget Amendment To Provide 10 Dental Hygiene Scholarships For Amounts Up To $5,000 Each ($50,000 GF); Language Also Would Be Included Directing The Board Of Health To Promulgate Regulations For Implementing The Program**

Option VI	**Introduce Legislation And An Accompanying Budget Amendment To Implement A Virginia Dentist Loan Repayment Program For Dentists Agreeing To Practice In Underserved Areas And/Or Providing Services To Underserved Populations (amount of budget amendment to be determined later)**
Option VII	**Introduce A Budget Amendment To Increase By Two Grade Levels The Salaries For Public Health Dentists A And B ($470,000 GF)**
Option VIII	**Introduce A Budget Amendment (Language Only) Directing The Virginia Department of Health To Report To The Governor And The General Assembly On Actions Being Taken To Ensure That Appropriated Funds Are Spent On Dental Services; Language Also Would Be Included Directing VDH To Study And Report On The Utilization And Condition Of Dental Trailers Used In Local Health Departments**
Option IX	**Introduce A Study Resolution Requesting The Virginia Department of Health To Conduct A Feasibility Study On Establishing Public Dental Health Programs To Serve Those Communities Currently Without These Services**
Option X	**Introduce A Resolution Requesting Virginia Commonwealth University/Medical College Of Virginia And The Dental School To Prepare And Submit A Plan To The Governor And The General Assembly For Establishing A Preceptor Or Externship Program For Dental Students To Gain Experience In Practicing In Underserved Areas And Populations**
Option XI	**Introduce Legislation To Authorize Less Restrictive Supervision Of Dental Hygienists Performing Certain Services In Specific Settings Such As Designated Dental Health Professional Shortage Areas, Public Schools, Public Health Clinics, Free Clinics, And Community Health Centers; Legislation Would Direct The Board Of Dentistry To Promulgate Regulations That Stipulate Requirements That Must Be Met Or Adhered To By Hygienists**
Option XII	**Introduce Legislation To Authorize Licensure By Endorsement For Dentists Who Agree To Provide A Specified Percentage Of**

Time Or Services For A Given Period (e.g. two years) In Specific Settings Such As Designated Dental Health Professional Shortage Areas, Public Health Clinics, Free Clinics, And Community Health Centers

Option XIII Introduce A Budget Amendment To Extend Dental Benefits To Adult Medicaid Eligibles (amount of budget amendment to be developed at a later time)

Option XIV Introduce A Study Resolution Directing The Joint Commission On Health Care To Continue Its Study Of Access To Dental Care By Examining Ways To Increase The Number Of Persons With Dental Insurance; The Study Also Could Examine Further The Need To Collect Additional Practitioner Data On Dental Hygienists, Monitor The Status Of The Medicaid Dental Program, And Follow-Up On Other Related Issues

APPENDIX A

HOUSE JOINT RESOLUTION NO. 644

Directing the Joint Commission on Health Care, in cooperation with the State Department of Health, the Department of Medical Assistance Services, the Virg Dental Association, the Virginia Dental Hygienists' Association, the Virginia Commonwealth University School of Dentistry, the Virginia Board of Dentistry, the Virginia Association of Free Clinics, and the Virginia Health Care Foundation, to study ways to increase access to dental care throughout the Commonwealth.

Agreed to by the House of Delegates, February 4, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, research has shown that uninsured persons are half as likely as insured individuals to visit a dentist regularly; and

WHEREAS, the 1996 Health Access Survey sponsored by the Virginia Health Care Foundation found that less than one-half of all Virginia households used dental insurance to pay for at least part of their dental care; and

WHEREAS, the 1996 Health Access Survey also found that 11 percent of survey respondents had not seen a dentist in over four years, and six percent reported they had never seen a dentist; and

WHEREAS, the lack of preventive and other dental care often can lead to serious, costly health conditions; and

WHEREAS, a recent report by the Division of Dental Health within the State Department of Health noted that there are dental care shortage areas in the Commonwealth; and

WHEREAS, there is limited data regarding the number and location of practicing dentists throughout the Commonwealth, which hampers dental workforce planning efforts; and

WHEREAS, a significant shortage of dentists participating in the Medicaid program adversely affects the dental health services available to Medicaid recipients; and

WHEREAS, the cost of tuition for dental school has risen significantly in recent years, causing an adverse impact on the recruitment of dental students, especially those from disadvantaged backgrounds; and

WHEREAS, concern has been raised regarding the adequacy of the number and dollar amount of dental scholarships currently available to dental students; and

WHEREAS, a comprehensive study of various issues regarding access to dental care in Virginia is needed to ensure that the greatest number of Virginians receive quality dental care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the State Department of Health, the Department of Medical Assistance Services, the Virginia Dental Association, the Virginia Dental Hygienists' Association, the Virginia Commonwealth University School of Dentistry, the Virginia Board of Dentistry, the Virginia Association of Free Clinics, and the Virginia Health Care Foundation, be directed to study ways to increase access to dental care throughout the Commonwealth. The study shall include, but not be limited to, an analysis of: (i) the need for practitioner data for dental workforce planning purposes; (ii) the financial, structural and other barriers to accessing dental care throughout the Commonwealth; (iii) dental practitioner shortage areas and ways to increase the number of dentists practicing in these shortage areas; (iv) the number of dentists participating in the Medicaid program and actions that would increase the number of participating dentists; (v) the current dental scholarship program and potential revisions to the program that may increase the number of dentists establishing practices in underserved areas; (vi) the actions taken in other states to increase access to dental care and to increase the number of dentists participating in Medicaid and practicing in underserved areas; and (vii) other appropriate issues which will increase access to dental care.

The Joint Commission shall submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
DENTAL STUDY
(HJR 644)

Individuals/Organizations Submitting Comments

A total of 23 individuals and organizations submitted comments in response to the HJR 644 report.

- AARP
- Administrative Council of the VCU School of Dentistry
- Dr. Carl O. Atkins, Jr., Pediatric Dentistry
- Blue Ridge AHEC
- Central Virginia Health Services, Inc.
- Mark A. Crabtree, DDS
- Dr. Christopher Hamlin
- James Madison University
- Northern Virginia AIDS Ministry
- Southside AHEC
- Southwest Virginia AHEC
- Paul Supan, DDS, MPH
- Virginia Association of Allied Health Professions
- Virginia Association of Free Clinics
- Virginia Department of Health
- Virginia Department of Health, Peninsula Health District
- Virginia Dental Association
- Virginia Dental Hygienists' Association, Inc.
- Virginia Poverty Law Center
- Virginia Primary Care Association, Inc.
- Virginia Rural Health Association
- Virginia Statewide AHEC Program
- Virginia Western Community College

Policy Options

Option I **Take No Action**

Option II **Introduce Legislation Providing The Virginia Department Of Health With Responsibility For Designating Virginia Communities As Dental, Medical, And Mental Health Professional Shortage Areas, And For Maintaining These Designations**

This legislation would need to be coordinated with any potential legislation emanating from the Health Workforce Study being conducted pursuant to the 1999 Appropriation Act. Depending on the actions taken as a result of that study, an accompanying budget amendment likely would be needed to provide additional staff (perhaps 2 FTEs) to assume this responsibility. (The amount of the budget amendment will be determined later.)

Option III **Introduce A Budget Amendment To Increase The Number Of Dental Scholarships To 10 And To Increase The Amount Of The Scholarships To $10,000 Each ($75,000 GF)**

Option IV **Introduce Legislation To Revise The Dental Scholarship Requirement That The Recipient Treat All Patients Regardless Of Ability To Pay; Contract Could Be Revised To Require The Dentist To Participate In Medicaid, Volunteer A Given Number Of Hours At A Free Clinic, Or Provide A Given Level Of Services At A Community Health Center Or Public Health Center**

Option V **Introduce A Budget Amendment To Provide 10 Dental Hygiene Scholarships For Amounts Up To $5,000 Each ($50,000 GF); Language Also Would Be Included Directing The Board Of Health To**

Promulgate Regulations For Implementing The Program

Option VI Introduce Legislation And An Accompanying Budget Amendment To Implement A Virginia Dentist Loan Repayment Program For Dentists Agreeing To Practice In Underserved Areas And/Or Providing Services To Underserved Populations (amount of budget amendment to be determined later)

Option VII Introduce A Budget Amendment To Increase By Two Grade Levels The Salaries For Public Health Dentists A And B ($470,000 GF)

Option VIII Introduce A Budget Amendment (Language Only) Directing The Virginia Department of Health To Report To The Governor And The General Assembly On Actions Being Taken To Ensure That Appropriated Funds Are Spent On Dental Services; Language Also Would Be Included Directing VDH To Study And Report On The Utilization And Condition Of Dental Trailers Used In Local Health Departments

Option IX Introduce A Study Resolution Requesting The Virginia Department of Health To Conduct A Feasibility Study On Establishing Public Dental Health Programs To Serve Those Communities Currently Without These Services

Option X Introduce A Resolution Requesting Virginia Commonwealth University/Medical College Of Virginia And The Dental School To Prepare And Submit A Plan To The Governor And The General Assembly For Establishing A Preceptor Or Externship Program For Dental Students To Gain Experience In Practicing In Underserved Areas And Populations

Option XI Introduce Legislation To Authorize Less Restrictive Supervision Of Dental Hygienists Performing Certain Services In Specific Settings Such As Designated Dental Health Professional Shortage Areas, Public Schools, Public Health Clinics, Free Clinics, And Community Health Centers; Legislation Would Direct The Board Of Dentistry To Promulgate Regulations That Stipulate Requirements That Must Be Met Or Adhered To By Hygienists

Option XII Introduce Legislation To Authorize Licensure By Endorsement For Dentists Who Agree To Provide A Specified Percentage Of Time Or Services For A Given Period (e.g. two years) In Specific Settings Such As Designated Dental Health Professional Shortage Areas, Public Health Clinics, Free Clinics, And Community Health Centers

Option XIII Introduce A Budget Amendment To Extend Dental Benefits To Adult Medicaid Eligibles (amount of budget amendment to be developed at a later time)

Option XIV Introduce A Study Resolution Directing The Joint Commission On Health Care To Continue Its Study Of Access To Dental Care By Examining Ways To Increase The Number Of Persons With Dental Insurance; The Study Also Could Examine Further The Need To Collect Additional Practitioner Data On Dental Hygienists, Monitor The Status Of The Medicaid Dental Program, And Follow-Up On Other Related Issues

Overall Summary of Comments

Overall, the comments were generally quite favorable on all policy options, except Option I. The following table summarizes the comments received on each Policy Option. Only those responses which specifically stated a position on the respective options are included in the table.

Policy Option	# Comments in Support	# Comments in Opposition	# Comments Citing No Position
I		5	
II	16		
III	12		
IV	12	1	
V	11	2	
VI	15		
VII	10	1	2
VIII	14		
IX	13		
X	14		
XI	12	2	
XII	10	2	1
XIII	13		
XIV	12	1	

Summary of Individual Comments

AARP

Norma McDonough, Chair, William L. Lukhard, Vice-Chairman, and Jack R. Hundley, Coordinator, commented in support of Options II - XIV. AARP supported these options in the following priority order: Option XIII; Option VIII; Options III - VII; Options XI and XII; and Options II, IX, X, and XIV.

Administrative Council of the VCU School of Dentistry

Ronald J. Hunt, DDS, MS, Harry Lyons Professor and Dean, VCU School of Dentistry, expressed strong support of Options II - VI, X, and XIII.

Dr. Carl O. Atkins, Jr., DDS, Pediatric Dentist

Dr. Carl O. Atkins, Jr. commented regarding oversight of the Medicaid dental program. He emphasized three main problems as prime deterrents for dentists to participate in the Medicaid program; namely, low reimbursement, patient compliance, and the administrative problems in dealing with the program. Additionally, he stated that a full-time dental consultant at DMAS is needed. He also indicated that DMAS is still responsible for the dental program that is contracted to HMOs and that they need to monitor the program more closely.

Blue Ridge AHEC

Christopher Nye, Executive Director, expressed support for Options II, III, IV, VI, and VIII through XIV. He expressed opposition to Option V because without general supervision of dental hygienists, a scholarship program would be of little value. Mr. Nye did not take a position on Option VII.

Central Virginia Health Services, Inc.

Roderick V. Manifold, Executive Director, expressed support for Options II, III, V-VIII, and X - XIV. Of these Options, Mr. Manifold

noted the strongest support for Options III, VI, VIII, X, XI, XIII, and XIV. In terms of Option VII, Mr. Manifold noted that this option is appropriate to consider after VDH has determined whether it will continue to operate dental programs in its many health districts. He expressed opposition to Option IX citing it as too narrow. Lastly, Mr. Manifold suggested that Virginia needs to consider funding a major project to provide a sealant program in the public schools.

Mark A. Crabtree, DDS

Mark A. Crabtree, DDS, stated that the Commonwealth has dentists on staff that are being directed by local health department policies to provide dental sealants (a delegable duty in Virginia) to otherwise healthy children. He further stated that it is a tremendous waste of the taxpayers funds to pay highly educated dentists to devote 80 to 100% of their time to applying dental sealants while patients in pain and experiencing more serious dental health problems are sent away. He also suggested that retention of qualified dentists is surely to suffer within the VDH if the doctors are required to perform tasks that a dental assistant can perform under his/her direction.

He recommended that the Commonwealth needs to develop a policy that determines and directs the best utilization of the dentists who are already on the state's payroll.

Dr. Christopher Hamlin, DDS (Pediatric Dentist)

Dr. Hamlin did not comment specifically on any of the Options. He indicated that while there is considerable discussion of scholarships, underserved areas, and lack of dental hygienists, there are no references to Pediatric Dentistry. He noted that Pediatric dentists see a disproportionate number of the "tough to treat" children which magnifies the problem associated with treating Medicaid patients. Dr. Hamlin indicated that there is a severe shortage of Pediatric Dentists in Virginia. He suggested increasing the stipend that graduate pediatric dental students receive during their training. He also recommended that the state consider providing tax relief in the form of a tax credit to those dentists who are heavily burdened by write-offs.

James Madison University

Vida S. Huber, R.N., Ed.D., Interim Association Dean, expressed support for Options II, IV, and VIII through XIV.

Northern Virginia AIDS Ministry

Nathan Monell, Co-Chair Public Affairs Committee, expressed support for Options XIII and XIV.

Southside AHEC

Woody B. Hanes, R.N., M.Ed., F.N.P, Executive Director, expressed support for Options II- X, XIII and XIV. She expressed opposition to Options I, XI, and XII.

Southwest Virginia AHEC

Eileen G. Lepro, MPH, CHES, Executive Director, generally supports the concepts expressed in Options II - XIV; however, they are concerned about the following specific items. Regarding Option III, Ms. Lepro recommended increasing the individual scholarship amounts, even if it means decreasing the total number of awards. Ms. Lepro indicated that while the Southwest Virginia AHEC is very supportive of Option X, it recommended that an effort be made to include rural and underserved localities in Southwest Virginia. She noted that the focus of Option XI should be on the ability to provide access to preventive care for thousands of children in the Commonwealth who are not receiving regular, periodic screenings, sealants, fluoride treatments, and most importantly, oral hygiene instruction. Lastly, they recommended that dental services become a mandate of the Virginia Department of Health, and that adequate funding support be provided to enable the provision of such services.

Paul Supan, DDS, MPH

Paul Supan, DDS, MPH, endorsed Option IX stating that he would like for private practice dentistry to have greater input into resolving important dental health challenges. Dr. Supan noted that he is particularly concerned about the role of local health directors in

defining the manner in which dental services are rendered. He also endorsed Option VII as a way to allow the Virginia Department of Health to attract and retain quality dentists. (Dr. Supan noted that he is not a public health dentist.)

Virginia Association of Allied Health Professions

Woody B. Hanes, RN, MEd., FNP, President, expressed support for Options II, and IV - XIII. She expressed opposition to Options I and XIV.

Virginia Association of Free Clinics

Mark R. Cruise, Executive Director, expressed support for Options II, VI, VIII - X, and XIV. With regard to Option VI, Mr. Cruise indicated such a loan repayment program also should be established for dental hygienists.

Virginia Department of Health

E. Anne Peterson, MD, MPH, Acting State Health Commissioner, expressed support for Options II - IX, and XII. In expressing support for Options IV and V, Dr. Peterson stated that VDH would need additional staff to implement these actions.

Virginia Department of Health, Peninsula Health District

Frank B. Sherman, DDS, Dental Director, stated that higher public health dentist salaries would help retain dentists and attract more qualified dentists. He also expressed concern regarding the flow of money for dental services between state and local governments.

Virginia Dental Association (VDA)

Dr. Charles L. Cuttino, III, President, indicated that the VDA opposes Option XI and XII and cited several reasons for VDA's opposition, most of which were discussed in the issue brief. Dr. Cuttino expressed support for the following actions: (i) providing VDH with responsibility for designating and maintaining dental HPSAs; (ii) addressing the number, amount and loan reimbursement criteria of dental and dental hygiene scholarships; (iii) addressing the current

situation that exists with public health dentists making certain they are appropriately reimbursed and making certain that funds allocated for dental services are actually spent on dental care; and (iv) establishing a preceptorship program for dental students. Dr. Cuttino also encouraged the Joint Commission to provide VDA with assistance as it continues to deliberate with DMAS to make certain reimbursement rates are sufficient.

Virginia Dental Hygienists' Association, Inc. (VDHA)

Jackie S. Perry, RDH, VDHA President, offered information regarding the training of dental hygienists in rebuttal to information that was presented in the report and attributed to VDA. VDHA expressed strong support for Option XI and support for Options II, III, V - VIII, and XIII. Additionally, Ms. Perry stated that Option XIV is positive but should not be introduced in lieu of action on the above options. Ms. Perry concluded by opposing Option I.

Virginia Poverty Law Center

Jill A. Hanken, Staff Attorney, expressed support for Options II - VIII, and X - XIV. In support of Option VIII, Ms. Hanken noted that it should be expanded to mandate dental services. Additionally, Ms. Hanken proposed one additional option: she noted that on September 1, 1999, DMAS was to have reported its new dental reimbursement methodology which increases dental fees to the 85th percentile of UCR. She encouraged the Joint Commission to support this increase by submitting a budget amendment to fund it.

Virginia Primary Care Association, Inc.

George Deebo, Deputy Director, expressed support and saw merit in varying degrees in Options II - XIV. Regarding Option V, he suggested adding language requiring these providers to work in practices treating all patients, similar to language in Option IV. He suggested adding the language, "Dental HPSAs" to Option VI to allow these areas to be used to satisfy service requirements. For Option VII, he suggested that legislation be introduced to limit the use of budget appropriations for dental care only for dental services. He also suggested that the Joint Commission consider redirecting any unused funds for dental care to providers currently serving the

underserved. Lastly, under Option X, he recommended adding language requiring coordination with organizations already providing or facilitating such dental student rotations such as VPCA's SCEPTER program and AHECs.

Virginia Rural Health Association (VRHA)

David E. Cockley, DrPH, President, expressed support for Options II-IV, VI, VIII - XI, XIII, and XIV. In support of Option XI, Dr. Cockley noted that this provision should be implemented through a pilot program. He expressed opposition to Options I, V, and VII. He noted that VRHA took no position on Option XII.

Virginia Statewide AHEC Program

Jeff Johnson, Statewide AHEC Director, endorsed Options II, VI, IX - XII and XIV.

Virginia Western Community College (VWCC)

Anne B. Hutcherson, RDH, MS, Associate Professor and Program Head, Dental Hygiene, provided information to correct factual errors regarding the number of dental hygiene students graduating from VWCC and the distant learning programs. She also expressed the strong support of the dental hygiene faculty for Option XI.

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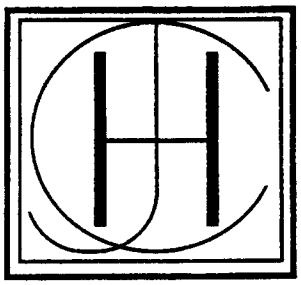

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