

THE
PEW
CHARITABLE TRUSTS

Making Coverage Matter: Keeping the Promise of the Affordable Care Act

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Pew Center on the States

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Agenda

- Overview of Pew Children's Dental Campaign
- Challenge: Why do we need workforce solutions?
- Opportunity: ACA Workforce Provisions
- A look at our workforce research portfolio





OUR WORK:

Fiscal Health

Government Performance

Election Initiatives

Partnership for America's Economic
Success

Pew Children's Dental Campaign

Pew Home Visiting Campaign

Pre-K Now

The Pew Children's Dental Campaign: Advancing Children's Dental Health

Our Mission:

The Pew Children's Dental Campaign strives for cost-effective policies that will mean millions more children get the basic dental care they need to grow, learn and lead healthy lives.



Focusing on Three Policy Areas

Prevention

- Community water fluoridation campaigns
- National messaging & strategy development

Funding for care

- Advocating for appropriations for oral health programs
- Medicaid reimbursement for fluoride varnish by MDs and RNs

Dental Workforce

- Ensuring adequate workforce to care for children
- Research on economics of new models





The
evidence
you need
to invest in
the
programs
that work.

Pew's Workforce Initiatives

State Level:

- Currently: MN, CA, ME
- Upcoming: NH, CT
- Publication: “Help Wanted” – decision framework for states

Federal Level:

- Secured provisions on DHAT in health care reform law
- Advocating for appropriations that support workforce

The Cost of Delay

State Dental Policies Fail **One in Five** Children

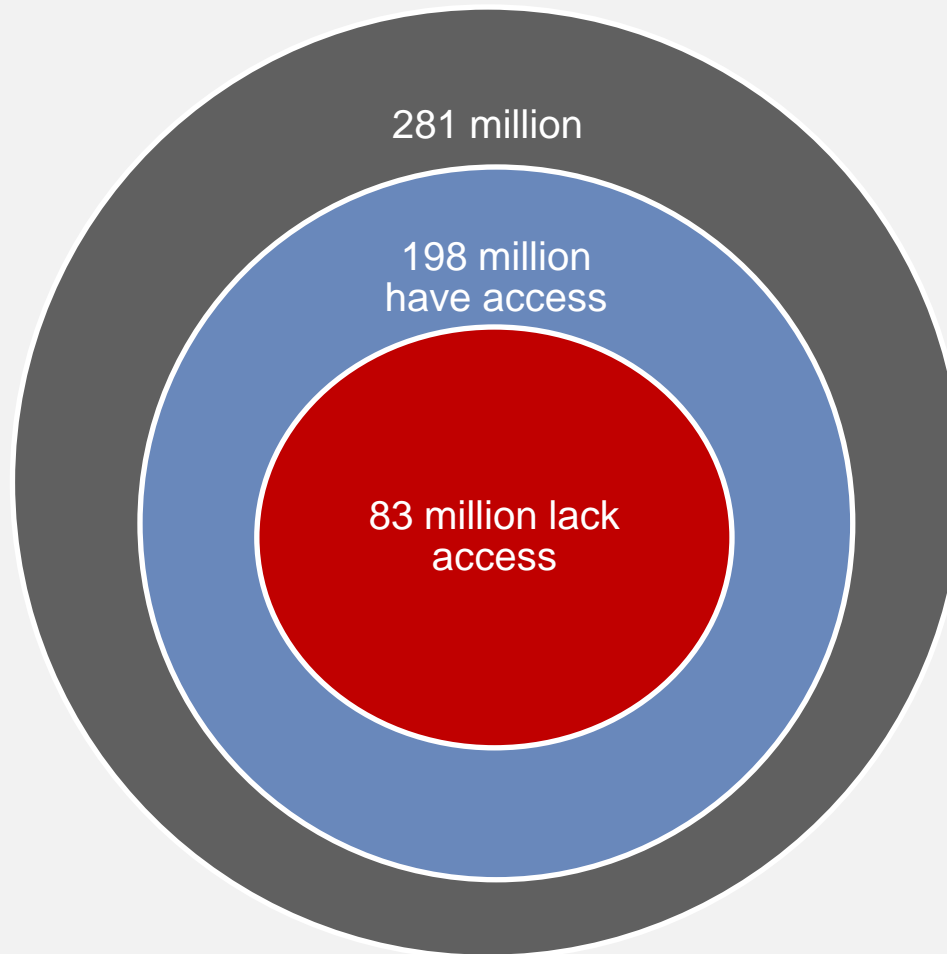


- Supported by W.K.Kellogg Foundation and DentaQuest Foundation
- Established 8 policy benchmarks
- Benchmark 7: New Primary Care Dental Providers



The Challenge: Why Do We Need Workforce Solutions?

One Third Lack Access



Limits of the Current System

More than **49 million Americans** live in an area federally designated as having a shortage of dental providers

“If you live in the suburbs, if you have a car, plenty of money, dental insurance, and no dental disease, we have the perfect delivery system for you.”

– *Charles Bertolami, dean of the New York University College of Dentistry*

More Kids, Same Old System

- Financing for dental care likely to grow, will spur demand
 - An estimated **5.3 million** more children will have dental insurance by 2014
- Few private-practice dentists participate in Medicaid and CHIP
 - Medicaid rate increases don't solve problem
- Shortage and maldistribution of dentists
 - Too few care for low income, rural patients
 - Dental safety net only reaches 10% of the 83 million lacking access
 - New providers can deliver high-quality care



Limits of the Private Practice System

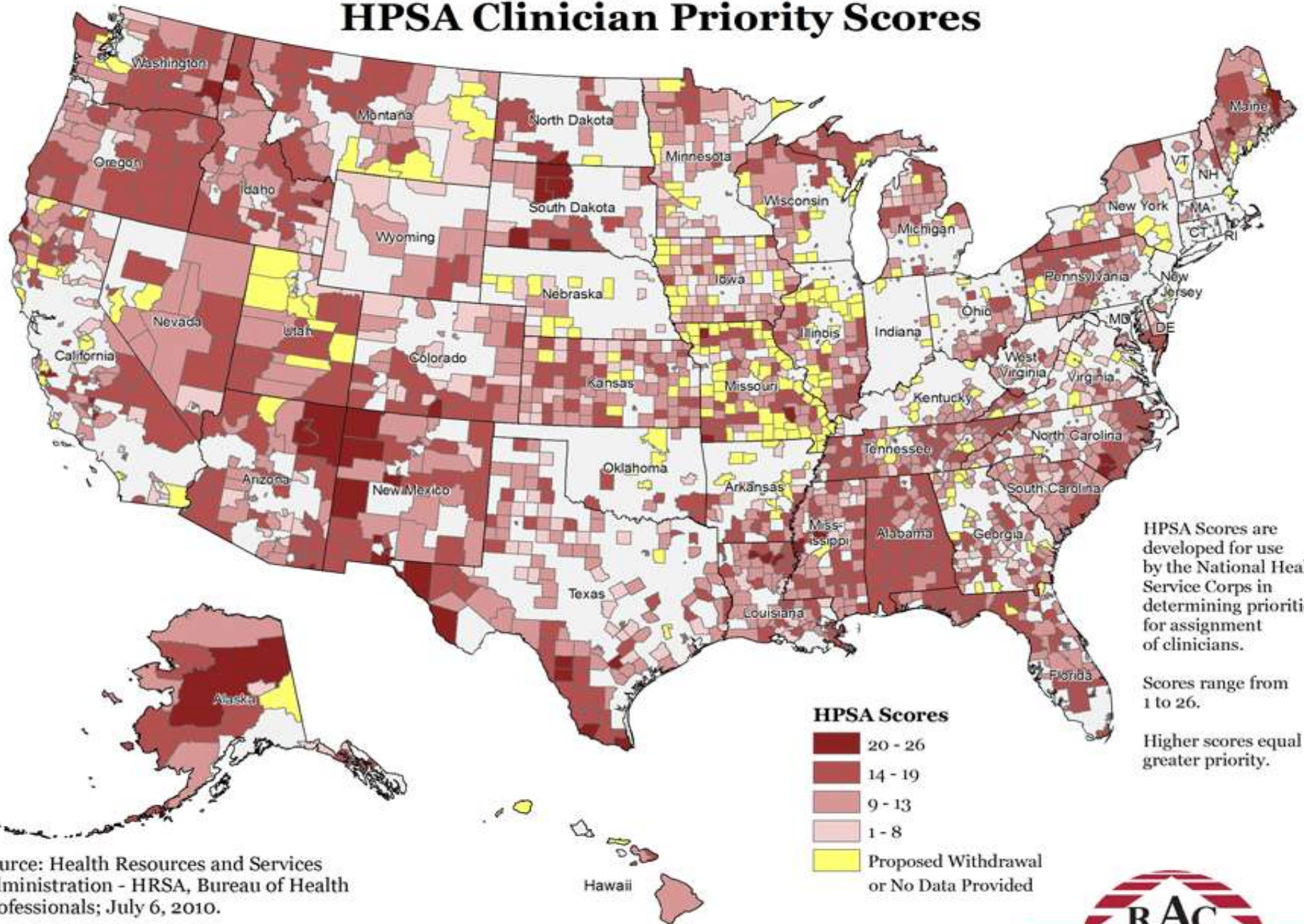
- Few dentists are skilled or equipped to care for special needs, disabled, non-ambulatory patients
- Very few dentists offer non-traditional hours or walk-in appointments
- Almost none provide enabling services such as translation, transportation or child care
- Very few services provided where kids are, such as schools and child care centers

Barriers to Care for the Underserved

- Low health literacy and expectations
- Medicaid and CHIP eligibility paperwork
- Lack of access to transportation, paid personal/sick days, and childcare

Health Professional Shortage Areas (HPSA) - Dental Health

HPSA Clinician Priority Scores



HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians.

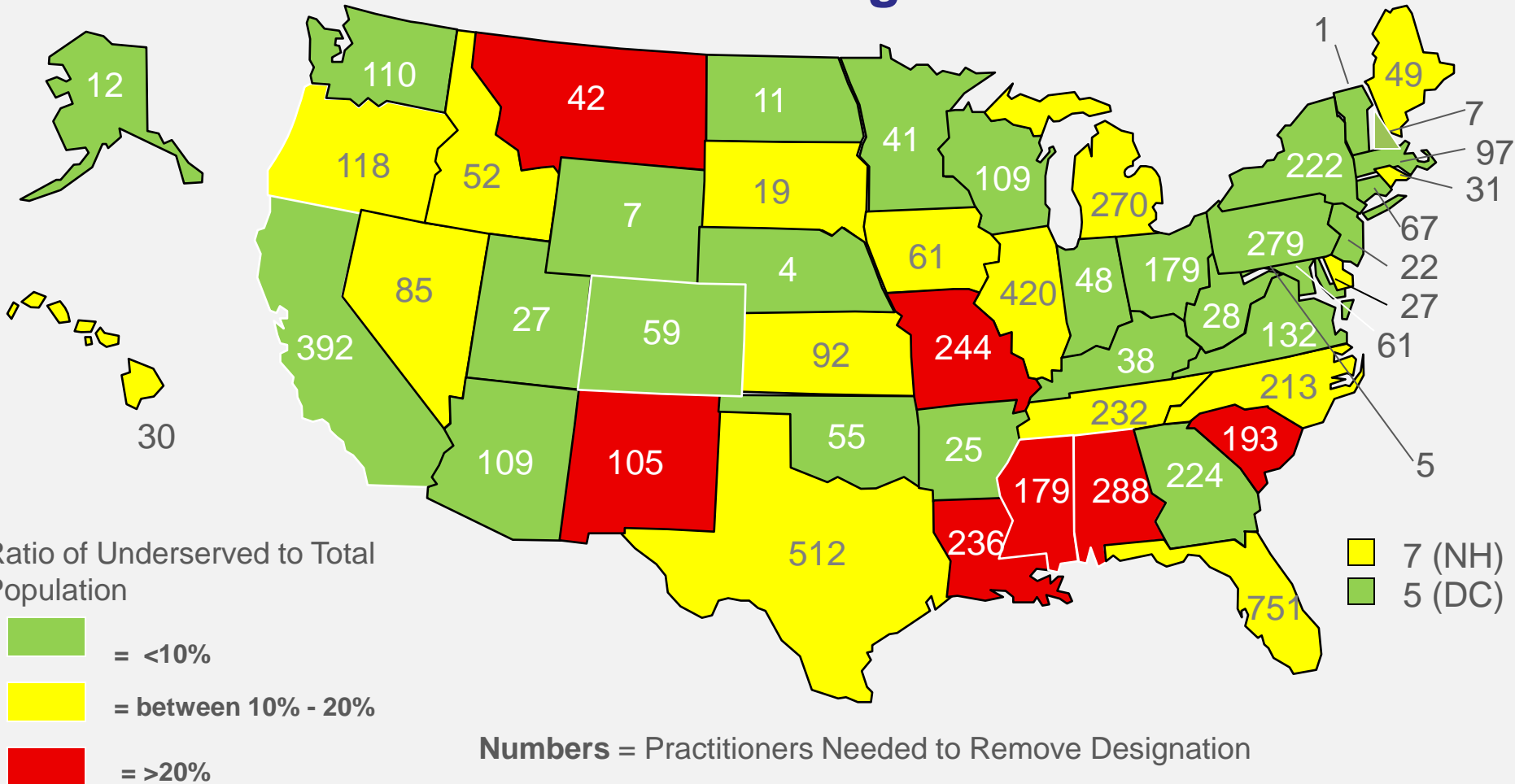
Scores range from 1 to 26.

Higher scores equal greater priority.

HPSA Scores

- 20 - 26
- 14 - 19
- 9 - 13
- 1 - 8
- Proposed Withdrawal or No Data Provided

6,620 Practitioners Needed to Remove Designation of Health Professional Shortage Area

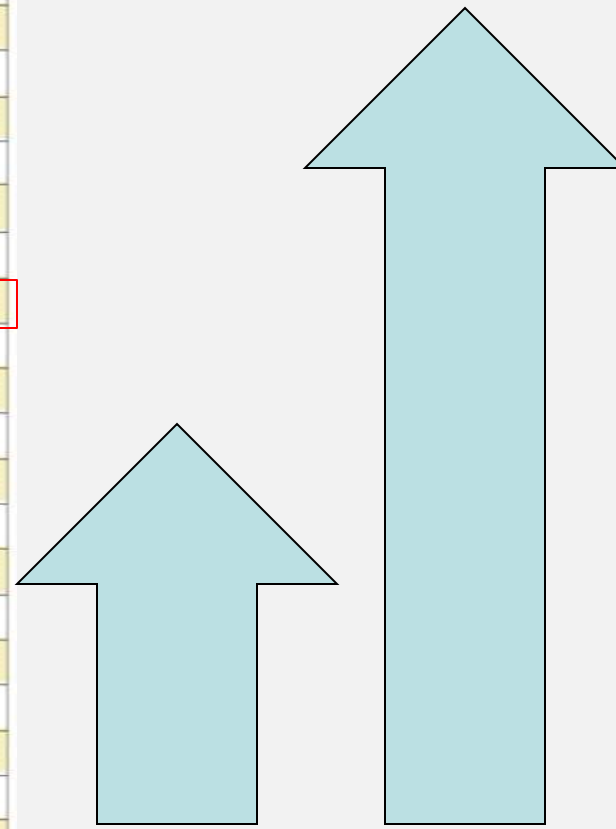


ESTIMATED NUMBERS OF RETIRING DENTISTS AND DENTAL GRADUATES, 2001-2020.

YEAR	DENTISTS RETIRING*	DENTISTS GRADUATING†	RATIO	DIFFERENCE
2001	3,546	4,090	.867	-544
2002	3,631	4,130	.879	-499
2003	3,754	4,172	.900	-419
2004	3,805	4,213	.903	-409
2005	4,028	4,256	.946	-228
2006	4,149	4,298	.965	-149
2007	4,226	4,341	.974	-115
2008	4,447	4,385	1.014	62
2009	4,563	4,428	1.030	135
2010	4,816	4,472	1.077	344
2011	5,029	4,517	1.113	512
2012	4,928	4,563	1.080	365
2013	5,117	4,608	1.110	509
2014	5,114	4,654	1.099	460
2015	5,114	4,701	1.088	413
2016	5,233	4,748	1.102	485
2017	5,060	4,795	1.055	265
2018	5,237	4,843	1.081	394
2019	5,003	4,892	1.023	111
2020	4,965	4,941	1.005	24

* Assumes that 20, 50, 20 and 10 percent of dentists retire after 40, 35, 30 and 25 years in practice, respectively, and that the average age of retirement is 62 years.
 † Based on the average annual rate of growth (1.0 percent) of first-year enrollments from the 1989 to 1990 school year to the 1998 to 1999 school year.

2008 Data:



Graduates entering field

Dentists retiring

The Financial Costs

Medicaid spends between **\$100 million** and **\$400 million** each year on children who end up in the operating room with advanced disease. These costs are avoidable.

- data from Burton L. Edelstein, DDS, MPH
The Cost of Caring: Emergency Oral Health Services

The Human Costs



Jacobi Hill
6 years old
Virginia



**Diamond
Brownridge**
5 years old
Chicago, IL



**Dylan
Stewart**
5 years old
Florida

The Human Costs: Sean Driver's Story

“It took the combined efforts of
one mother, **one** lawyer, **one** helpline supervisor, and
three health care case management professionals
to make a dental appointment
for a single Medicaid-insured child!”

— Laurie Norris, JD; Congressional Testimony

The Opportunity: ACA Workforce Provisions

ACA Supports Dental Workforce Expansion

- Most of the new dental provisions in ACA are authorized but not appropriated
- Money appropriated in ACA is not specifically targeted to dental access issues
 - Community health center funding
 - Prevention and Public Health Trust Fund
- Work still remains to be done to adequately fund these provisions

ACA Supports Dental Workforce Expansion

Demonstrations and evaluation of alternative dental health care providers (Title V, Sec. 5304)



Timing: 5-year program to begin no later than March 23, 2012, funding can start in March 2011

Agency: Secretary of Health and Human Services; Director of the Institute of Medicine contracted at end to study programs

Funding: Authorized, but not funded; each grant will be at least \$4 million, to be distributed over life of 5-year project – total of at least \$60 million

Authorization: New

ACA Supports Dental Workforce Expansion

Expanded dental training programs (Title V, Sec. 5303)

Timing: FY 2010 - FY 2015

Agency: Secretary of Health and Human Services

Funding: FY 2010: Authorized and funded; \$30 million
FY 2011-FY 2015: such sums as necessary

Authorization: New/Existing (creates a new line-item)

ACA Supports Dental Workforce Expansion

New or expanded primary care residency programs, including dental programs (Title V, Sec. 5508)

Timing: FY 2010

Agency: Secretary of Health and Human Services

Funding: Authorized, but not funded; \$25 million for FY 2010, \$50 million for FY 2011 and FY 2012, and such sums as necessary for each fiscal year thereafter.

Authorization: New authorization



ACA Supports Dental Workforce Expansion

Funds for Community Health Centers (Title X, Section 10503)

Timing: FY 2011-2015

Agency: Secretary of Health and Human Services

Funding: \$11 billion appropriated for Community Health Center Fund to construct, expand, and sustain community health centers from FY 2011-2015

Authorization: New authorization

Two Potential Sources of Funding

* Funding from the Prevention and Public Health Fund

The law establishes a fund, to be administered through the Office of the Secretary at HHS, to provide for a sustained national investment in prevention and public health programs (over the FY 2008 level).

FY 2010:	\$500 million; \$250 million directed to health care workforce
FY 2011:	\$750 million
FY 2012:	\$1 billion
FY 2013:	\$1.25 billion
FY 2014:	\$1.5 billion
FY 2015:	\$2 billion <u>and each fiscal year thereafter...</u>

* New direct/mandatory funding

Our Workforce Research Portfolio



University of California, San Francisco Center for the Health Professions

Lead investigators

Elizabeth Mertz, PhD, MA, and Catherine Dower, JD

Question

How can medical collaborative practice models be applied to and affect the dental care delivery system?

Expected Release Date

December 2010

UCSF Study will:

Explore what states could mean by ‘collaborative practice’

1. Collaboration between Operationally and Legally Independent Providers
2. Collaboration between Operationally Independent Providers
3. A Single Health Care Organization
4. A Public Health Entity
5. Ancillary Settings



University of Connecticut Health Center (UCHC)

Lead investigators

Howard Bailit, D.M.D., Ph.D. and Tryfon Beazoglou, Ph.D.

Question

What are the likely effects of new dental care providers on FQHCs, and what is the most effective way to utilize those providers to increase access to care?

Expected Release Date

Spring 2011

UCHC Study will:

- Evaluate data from FQHCs in CA, ME, WI, CT
- Provide economic model to estimate impact of new providers on FQHC dental clinic productivity and finances under two conditions:
 - (a) new provider training and delivery system organizations
 - (b) Medicaid program design and FQHC payment methods and reimbursement rates.
- Test economic model on selected FQHC dental programs

Scott & Company

Lead investigator

Mary Kate Scott

Question

What are the potential economic impacts of hiring new allied dental care providers to a dentist practice?

(An Excel file “calculator” will be available for download by any user.)

Release early November

www.pewcenteronthestates.org/dental

Scott & Company Tested...

- Three scenarios:
 - Solo pediatric practice
 - Solo general practice
 - Small group practice
- Tested varying levels of provider utilization, Medicaid participation, and Medicaid payment rates
- Tested 3 kinds of allied providers: dental hygienist, dental therapist, and combination hygienist-therapist
- In most cases, increases were seen in productivity and pre-tax profits
- High utilization is key in instances where Medicaid payment is low

Scott & Company: Key Findings

- By using new providers, providers can:
 - Increase profitability
 - Increase productivity
 - See more patients, including Medicaid patients, while sustaining profitability and productivity



One Scenario: Solo General Dental Practice

- Structure:
 - One dentist, two dental assistants, and admin. support
- Operations and profit:
 - Hiring allied provider resulted in higher profit in most cases
- Productivity:
 - Addition of each allied provider increased productivity
- Medicaid:
 - Adding dental therapist or hygienist-therapist allowed practice to devote up to 20 percent of time to Medicaid-enrolled patients and see modest income gains in 3 of 4 cases

Solo General Dentist: The Impact

Allied Providers' Impact on a Solo General Dental Practice

PROFIT IMPACT



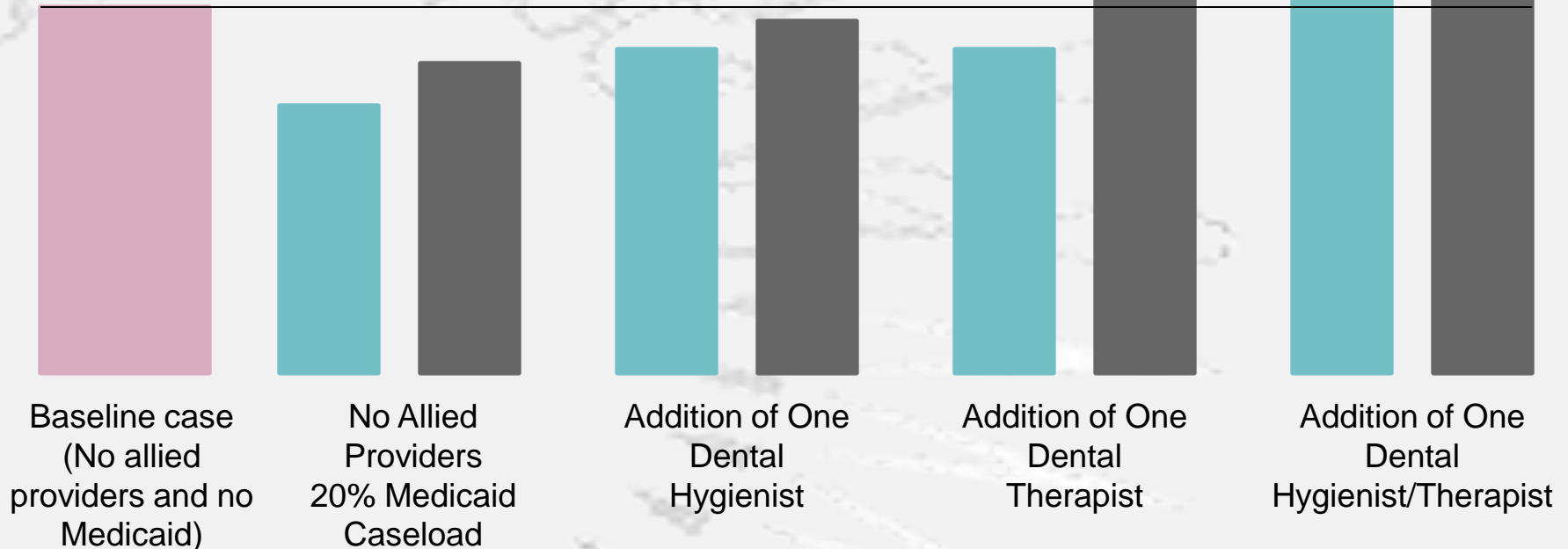
PRODUCTIVITY IMPACT



Solo General Dentist: The Impact (20% Medicaid)

Profit Impact on a Solo General Dental Practice Serving 20% Medicaid Patients

■ 30% reimbursement rate
■ 60% reimbursement rate



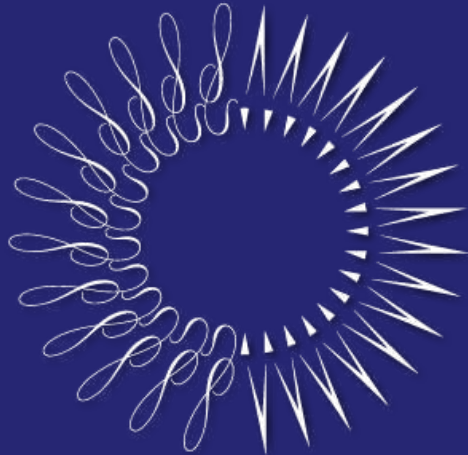
Scott & Company: Policy Implications

- Dental schools should train students to work effectively with allied providers and manage team
- Medicaid payment rates should be above cost of providing the care
- State Medicaid programs should help ensure that patients have means necessary to make and keep appointments
- State leaders and Medicaid administrators should ensure that policies allow reimbursement for services provided by newly hired allied providers

The Takeaway

We have tremendous challenges, and new opportunities. What we've been doing hasn't worked for 1/3 of the population. The ACA and new workforce models have potential to increase access for children who need it most.





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