

Report of the Governor's Task Force to Improve Access to Oral Health



Submitted to Governor Jim Doyle
June 13, 2005



Special Thanks

Governor's Task Force to Improve Access to Oral Health

MEMBERS

Erendira Almanza, RDH
Madison

Monica Hebl, DDS
Milwaukee

Lori R. Barbeau, DDS
Milwaukee, WI

Wendy MacDougall, RN
Menomonie

Bill Bazan
Milwaukee

Senator Mark Miller
Monona

Stephanie Burrell, DDS
Oneida

Maureen Oostdik-Hurd, RDH
Madison

David Carroll, RDH, BSM
Weston

Midge Pfeffer, RDH
Milwaukee

Blane Christman, DDS
Ladysmith

Carrie Stempski, RDH
Green Bay

Carl Eisenberg, MD
Mequon

Graciela Villadoniga, MD
Milwaukee

Representative Curt Gielow
Mequon

Special thanks to all the organizations and individuals who shared their experience, knowledge and insight on oral health care in Wisconsin. This report and the resulting actions would not have been possible without your interest in improving access to oral health in Wisconsin.

Staff: Robert Dwyer, DDS, Warren LeMay, DDS, Kay Lund, Nancy McKenney, RDH, Andy Snyder, Diane Welsh, Donna Wong



GOVERNOR'S TASK FORCE TO IMPROVE ACCESS TO ORAL HEALTH

June 13, 2005

Governor Jim Doyle
115 East State Capitol
Madison, WI 53702

Dear Governor Doyle:

We are pleased to present to you the final report of the Governor's Task Force to Improve Access to Oral Health in Wisconsin.

The challenges to improving access to oral health care are daunting but since being appointed to this Task Force, we have been dedicated to the charge set before us. Many of the recommendations in this report were unanimous. Some recommendations have dissenting views that are noted in the report. Regardless of our differing backgrounds and despite our differing views, we worked together to come up with innovative, practical solutions for our oral health access problems in Wisconsin.

We would like to thank you for the opportunity to contribute to this critical effort. We hope you agree that our recommendations will advance our ability to provide access to dental care for all people in Wisconsin and especially for children.

Sincerely,

Erendira Almanza

Monica Hebl

Lori R. Barbeau

Wendy MacDougall

Bill Bazan

Mark Miller

Stephanie Burrell

Maureen Oostdik-Hurd

David Carroll

Midge Pfeffer

Blane Christman

Carrie Stempski

Carl Eisenberg

Graciela Villadoniga

Curt Gielow

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ORAL HEALTH NEEDS IN WISCONSIN

In many areas across Wisconsin, families and individuals have a difficult time obtaining adequate access to dental care services. Finding care is most difficult for those that are uninsured or for those enrolled in the Medicaid and BadgerCare programs.

A variety of obstacles may deter individuals from obtaining the care they need. These barriers may be financial, geographic, perceptual, educational, linguistic, cultural or provider-related.

The resulting lack of oral health care can cause children to suffer delays in growth and development and often experience delays in learning and in social development. Poor teeth can force adults to deal with constant pain and to be uncomfortable in social and work settings because of their appearance.

Oral health is one of the most pressing public health needs in the state and tooth decay is largely preventable.

Although dental caries (tooth decay) is largely preventable, once established, the disease requires treatment. A cavity only grows larger and more expensive to repair the longer it remains untreated.

“Oral health is integral to general health. You cannot be healthy without oral health. Oral health and general health should not be interpreted as separate entities.”

U.S. Department of
Health and Human Services:
“Oral Health in America:
A Report of the Surgeon General,”
2000

In Wisconsin today, tooth decay is the most common chronic childhood disease – five times more prevalent than asthma.

- According to the Department of Health and Family Services' *Make Your Smile Count* Survey, about 30 percent of Wisconsin third-graders have untreated tooth decay; four percent needed urgent care.
- According to the Department of Health and Family Services' *Healthy Smiles for a Head Start* data report, 24 percent of children (ages 3 to 6) in surveyed Head Start programs had untreated decay.
- A significantly higher proportion of children of color had untreated decay. Twenty-five percent of white children screened had untreated decay compared to 50 percent of African American, 45 percent of Asian American, and 64 percent of Native American children.
- Children attending lower income schools had significantly more untreated decay (44.5 percent) compared to middle income (31.7 percent) and higher income schools (16.6 percent).
- Only one in four children enrolled in Medicaid receives any dental care.

Wisconsin is not alone on this issue, as states across the nation are struggling with how to improve access to oral health care. Fortunately, in Wisconsin, the importance of this issue has been recognized. In his KidsFirst Initiative, Governor Jim Doyle presents a strategy for protecting the health and well-being of children and families in Wisconsin.

KIDSFIRST

In his **KidsFirst Initiative**, Governor Doyle recognized the need to improve access to dental care in Wisconsin. The initiative includes:

- Increasing access to dental sealants, one of the most effective strategies in fighting tooth decay. The Governor's 2005-07 budget proposal doubles the funding for the Healthy Smiles for Wisconsin (Seal-a-Smile) program to \$120,000 annually.
- Allowing Medicaid reimbursement to pay for topical applications of fluoride to reduce the risk of decay. In February 2004, Governor Doyle directed Medicaid to reimburse health care providers for topical applications of fluoride. These applications can be provided by nurses and dental hygienists employed at certified HealthCheck nursing agencies, and by physicians, physician assistants, and nurse practitioners.
- Providing funding to technical colleges to provide dental care to low-income and uninsured children and to train students to be dental hygienists and assistants. In the Governor's 2005-07 budget proposal, he included \$86,100 annually to help two technical colleges expand their efforts to train dental health professionals and provide services to low-income and uninsured children.
- Certifying dental hygienists as Medicaid providers.
- Appointing a Governor's Task Force to analyze and offer solutions to address the shortage of access to oral health services. This Task Force began meeting in October 2004.

TASK FORCE CHARGE

As part of the KidsFirst Initiative, Governor Doyle called for a task force to analyze and offer solutions to address the shortage of dental care professionals and children's access to dental care in Wisconsin. He directed his office to create the task force and to develop policy recommendations on the following issues.

1. Recommend strategies for educating an adequate number of dental health professionals if the state is not currently doing so.
2. Recommend strategies for how communities and the state might better recruit and retain dental professionals throughout Wisconsin.
3. Recommend strategies for how the state can improve access to dental care for children in Medicaid and BadgerCare.
4. Recommend ways to improve access for all children and to provide better preventative dental care.
5. Recommend most effective ways to spend Medicaid dollars on preventative care.

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EXECUTIVE SUMMARY OF TASK FORCE ACTIONS

Although seeing a dentist on a regular basis is an ordinary component of health care for many people in Wisconsin, across the state many individuals are not getting the oral health care that they need. For some, education about the importance of ongoing, preventive oral health care is lacking. These people often seek care only in crisis situations. For those who understand that oral health care is a priority, they find that getting an appointment can be difficult and frustrating.

Governor Doyle appointed the Task Force on Improving Access to Oral Health to help identify barriers to knowledge and access and find solutions.

In this report, you will find a short history of the oral health crisis and a summary of Wisconsin's Medicaid program. Following these sections, you will find a summary of discussions by the Task Force and their recommendations on topics relating to improving access to oral health.

Summary of Recommendations

Dental Professionals Workforce Recruitment, Training and Loan Assistance

Wisconsin operates a loan program that provides for repayment of dental school loans for dentists and dental hygienists who agree to practice primary care in designated shortage areas in Wisconsin. The Task Force recommended that the state maintain or increase funding for this program and that loan assistance could also be provided based solely on serving Medicaid clients.

Marquette University School of Dentistry

The state's only dental school, Marquette University School of Dentistry, receives a subsidy to reduce the tuition for Wisconsin residents who attend this dental school. The Task Force recommended that the state increase funding to cover 50 Wisconsin residents in each future class and increase the amount per student to \$11,670.

Community Water Fluoridation

Community water fluoridation is the process of adjusting the amount of fluoride that occurs naturally in a community's water to a level that will prevent tooth decay.

The Task Force recommended that the state increase funding to assist communities to fluoridate their water supplies.

The most common benefits of community water fluoridation include:

- 15 to 40 percent less dental decay;
- six times as many children free of dental decay;
- 75 percent fewer extracted permanent first molars in children;
- 95 percent fewer cavities in children's upper front teeth.

Dental Hygienist Workforce

Dental hygiene is the performance of educational, preventive or therapeutic dental services and may be practiced as authorized by a dentist. The Task Force recommended that the state change the statutes to expand the types of settings where dental hygienists may practice independently of a dentist.

Medicaid Funding and System Changes

Eligible children can receive dental care under the Medicaid or BadgerCare programs. Care providers are provided a fee-for-service reimbursement rate in most of the state. In four southeastern counties, providers are paid based on a rate negotiated under the HMO dental delivery system.

The Task Force recommended that the state increase the Medicaid dental budget by \$20 million in state funds and that this investment in the dental Medicaid program be used on pay for performance strategies that guarantee increase access. The Task Force supported a soda tax to help fund dental program increases. The Task Force also recommended that the state develop a request for information on a dental benefits administrator to manage all Wisconsin's dental care claims. Several recommendations were made relating to the responsibilities of dentists providing care and patients seeking care.

Dental Licensure

Dentists who wish to be licensed in Wisconsin must meet certain requirements as determined by state statutes and the Dentistry Examining Board. The Task Force recommended that the state accept all four of the existing regional exams, and the national exam when it is approved. Also, the Task Force recommended that the state create a pathway for foreign-trained dentists to receive licensure by demonstrating competency in an approved residency program.

Oral Health Safety Net Program Funding

Ten of Wisconsin's Federally Qualified Health Centers (FQHCs) have dental programs. These sites provide access to dental services for many low-income individuals that would otherwise not receive care. The Task Force recommended that the state develop a council that would define criteria and award funding to programs that improve oral health access for Wisconsin's children.

Children with Special Health Care Needs and Targeted Case Management

Children in the Wisconsin Children with Special Health Care Needs program may be eligible for Targeted Case Management that assists recipients and their families in gaining access to services for which they are eligible. The Task Force recommended that the state make local health departments aware that children with severe oral health needs may meet the criteria of the Children with Special Health Care Needs program, thus permitting these children to receive Targeted Case Management services.

Regional Oral Health Operations

Oral health consultants with the Department of Health and Family Services help local communities develop oral health programs through training and technical assistance. They are involved in school-based fluoride mouthrinse programs, school oral health surveys, school and community dental sealant programs, and the SmileAbilities program for children with special health care needs.

The Task Force recommended that the state increase the contract hours of the oral health regional staff and that each regional office have portable dental equipment available for community programs.

Advocacy, Education, School Based Initiatives, and Local Public Health



True prevention requires an understanding of the importance of oral health as well as access to dental health professionals. The 2000 Surgeon General's report stated: "You cannot be healthy without oral health."

The Task Force recommended that the state increase lobbying efforts with the federal government to secure additional resources for oral health, increase oral health education in our schools, and work with other health care providers to integrate oral health in all health care practices.

School-based programs allow children to receive oral health care without addressing the existing hurdles to care such as transportation to the dentist, parent's ability to take off work, or a lack of understanding of the need for preventive care. The Task Force recommended that the state provide funding for several pilot programs that demonstrate coordination of oral health care by local public health departments and school districts.

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SUMMARY OF MEETINGS

At the **October 22, 2004** meeting, the Task Force received their charge from the Governor consisting largely of two components: education as it relates to the recruitment, training and retention of providers; and access to care. They received presentations on the KidsFirst Initiative, background information on the current oral health environment in Wisconsin and on the 2000 Legislative Council Special Committee on Dental Access. The members were provided with a list of prevention and restorative programs that are funded with state and federal funds.

At the **November 19, 2004** meeting, the Task Force addressed evidence-based prevention topics including fluoride applications and community water fluoridation, oral health training and education, and dental sealants.

At the **December 10, 2004** meeting, presentations were given by the Wisconsin Dental Association, the Wisconsin Primary Health Care Association, the Wisconsin Dental Hygienists Association, the Dental Hygiene Association of Wisconsin, the Marquette University School of Dentistry, the Madison Area Technical College Dental Hygienist program, and the Department of Regulation and Licensing. Much of the discussion focused on how to get dentists to practice in shortage areas. The members participated in a preliminary brainstorming session on recommendations at the end of the meeting.

At the **January 7, 2005** meeting, the Task Force heard presentations from the Department of Health and Family Services on Medicaid, BadgerCare, and HMO dental services; and from the Wisconsin Dental Association on their five recommendations to improve access to oral health. Much of the discussion focused on HMO dental services that will be addressed at a future meeting.

At the **January 14, 2005** meeting, the Task Force discussed the overall issue of the state needing to make oral health a financial priority. The members then began to consider recommendations on issues relating to the dental health professional workforce, public health education, and Medicaid reimbursement.

At the **February 18, 2005** meeting, the Task Force made recommendations on loan forgiveness and tuition assistance, Marquette University School of Dentistry funding, public health education, and expanded practice settings for dental hygienists. A discussion on reimbursement rates led the task force to request more information about several rate increase models. A discussion on foreign-trained dentists also ended without a final recommendation.

At the **March 11, 2005** meeting, the Task Force began with a discussion on the reimbursement rate models requested at the February 18 meeting but no consensus was reached. Final recommendations were made on the practice of dental hygienists. The Task Force requested more information on several remaining topics for the next meeting. Finally, a recommendation was made on funding for community fluoridation.

At the **April 8, 2005** meeting, the Task Force heard a presentation on federally qualified health clinics from the Wisconsin Primary Health Care Association, from Marshfield Clinic's Ladysmith dental organization, and from the Wisconsin Office of Rural Health. The members also received a report on managed care dental services in four southeastern Wisconsin counties. Recommendations were made on HMO dental care.

At the **April 15, 2005** meeting, the Task Force heard presentations on the Maternal and Child Health block grant budget that includes some funding for oral health programs and on the Children's Hospital of Milwaukee Clear Path program. Several recommendations were made on these topics and on other issues left before the Task Force. The Task Force addressed priorities set aside at previous meetings.

At the **May 13, 2005** meeting, the Task Force held a public hearing on the recommendations proposed to improve access to oral health. Following the public hearing, the members addressed several remaining issues and changes to existing recommendations based on the information received at the public hearing.

At the **May 24, 2005** meeting, the Task Force met to take a final vote on recommendations to Governor Doyle. The members reviewed each of their recommendations to make their intentions more clear, to group similar topics, and to address final access concerns.

HISTORY OF THE ORAL HEALTH CRISIS

In the first comprehensive report on oral health in America, Surgeon General David Satcher's message was that oral health is essential to the general health and well-being of all Americans *and* can be achieved by all Americans.

“Oral Health in America: A Report of the Surgeon General,” 2000

The report found that oral health diseases and conditions are associated with other health problems and that there is a need for education on general behaviors that can prevent poor oral health. It also emphasized that there are profound and consequential oral health disparities within the American population.

"Because we look at teeth as expendable, we diminish the impact of the pain and the disease. However, research showing the correlation between dental and cardiac diseases in adults, and poor nutrition and growth, low self-esteem, missed school days and other medical complications in children brought this public health issue to the legislative floor in many states. "

Connecticut Representative Vicki Orsini Nardello remembers that "five years ago you could not get a legislative discussion on oral health." She attributes this to our attitude toward dental health.

The report says that those who suffer the worst from this "silent epidemic" of oral diseases are the poor, particularly children and older persons. Members of racial and ethnic minority groups experience a disproportionate level of oral health problems, and the health of medically compromised people and those with disabilities is placed into further jeopardy by oral disease.

The 2000 Surgeon General's Report concluded with a framework for action, calling for a national oral health plan to

improve quality of life and eliminate oral health disparities. Although the Report stimulated action on oral health disease prevention and access problems, there was a need for communication and coordination of efforts across the nation. The Office of the Surgeon General extended an open invitation to organizations to launch the development of the **Call To Action in 2003**. The resulting Partnership Network developed five actions that would help states meet their oral health goals.

Action 1: Change Perceptions of Oral Health. For too long, the perception that oral health is in some way less important than and separate from general health has been deeply ingrained.

Action 2: Overcome Barriers by Replicating Effective Programs and Proven Efforts. We need to promote and apply programs that have demonstrated effective improvement in care and that reduce barriers to access. We also need to enhance oral health promotion and literacy.

Action 3: Build the Science Base and Accelerate Science Transfer. Too many people outside the oral health community are uninformed about oral health. Advances in research and understanding can lead to interventions that will improve prevention, diagnosis, and treatment.

Action 4: Increase Oral Health Workforce Diversity, Capacity, and Flexibility. Develop ways to expand and build upon successful recruitment and retention programs, especially in under-represented racial and ethnic groups. Expand efforts to expand the dental health professional workforce in shortage areas. Secure an adequate and flexible workforce

Action 5: Increase Collaborations. Building public-public and public-private coalitions capitalizes on the talent and resources of each partner.

**Legislative Council Study Committee:
Special Committee on Dental Care Access, 2000**

This Committee was charged with examining ways to increase access to dental care for Wisconsin's underserved populations, particularly

those enrolled in Medical Assistance and BadgerCare. The Committee: examined the sufficiency of the number of dental care professionals in Wisconsin and the location of their practices; the number of Medicaid, BadgerCare, and other low-income persons they serve; ways to increase dental services being provided to underserved populations in Wisconsin; and reimbursement and administrative issues surrounding the provision of dental services under the Medicaid and BadgerCare programs. The Special Committee reported its recommendations to the Joint Legislative Council in January 2001.

The committee's recommendations resulted in two pieces of legislation introduced in each house (2001 Senate Bills 166 and 167 and 2001 Assembly Bills 366 and 367).

These bills would have increased the dental Medicaid reimbursement rate to the 75th percentile, expanded the functions for dental hygienists, provided greater delegation authority to dentists, provided coverage under the state Medicaid program of topical fluoride varnishes, increased the number of Wisconsin students at the Marquette University School of Dentistry, and provided funding for community fluoridation.

Neither bill was enacted into law but several topics were addressed in other proposals and enacted.

MEDICAID COVERAGE FOR DENTAL SERVICES IN WISCONSIN

Wisconsin provides basic dental benefits to children and adults eligible for Medicaid or BadgerCare. Wisconsin Medicaid spent almost \$40 million on oral health care in Fiscal Year 2004.

The Wisconsin Medicaid program is a joint federal and state program providing medical benefits to certain categories of families and pregnant women and children with low incomes or disabilities. The federal government provides approximately 60 percent of the funding for the Medicaid program and governs the basic structure of the program.

Medicaid

Under Medicaid, states are required to provide 40 percent in matching funds and certain mandatory services, but have discretion regarding coverage of optional services and direct administration of the program.

BadgerCare

BadgerCare is the state's version of the federal children's health insurance program. Under BadgerCare, services provided are identical to those provided under the Medicaid program. However, the eligibility criteria are different. Generally, BadgerCare covers persons who are above the eligibility requirements for Medicaid but have incomes at or below 185 percent of the Federal Poverty Level. BadgerCare may require a monthly premium if family income is greater than 150 percent of the Federal Poverty Level.

Under federal law, all states are required to provide any medically-necessary dental services to Medicaid-enrolled children that are found as a result of a screening conducted under the provisions of the Early and Periodic Screening, Detection, and Treatment (EPSDT) program. In Wisconsin, the EPSDT program is known as HealthCheck. Adult dental coverage is optional under Medicaid. During these challenging fiscal times, many states, among them Michigan and Minnesota, are decreasing coverage for adult dental services or imposing considerable limitations.

Covered Dental Services under Medicaid and BadgerCare

There are frequency limitations on services. For example, dental cleanings are limited to two cleanings per year for children and one per year for adults. In addition, there are prior authorization requirements for several of the services covered under Medicaid and BadgerCare. Dental Medicaid providers are required to obtain prior authorization approval from the Department of Health and Family Services prior to the provision of specific dental services.

Medicaid Reimbursement

Fee-For-Service: Under Wisconsin Medicaid and BadgerCare, the rate of reimbursement for services is based on the Medicaid dental maximum fee schedule. A provider is reimbursed the lesser of either the billed amount or the maximum allowable fee established under the MA program. The current Medicaid reimbursement rates for dental services are approximately 46 percent of billed charges for adult dental services. Reimbursement for children's services is slightly higher.

In the fee-for-service system, clients are responsible for locating Medicaid-certified dentists, and calling them to see whether they are accepting new patients. Very few dentists are, and most that do place restrictions on admissions by patient age or place of residence, and dismiss patients from their practice for missed appointments.

The Department of Health and Family Services is pursuing several initiatives to improve the fee-for-service program to help clients find care. The Department is developing a list of dentists that are accepting new patients. To reduce the administrative burden to providers, the Department has made efforts to streamline the paperwork by adopting the American Dental Association claim form and other improvements. Rule changes are in process to reduce the number of services requiring prior authorization. The Department has developed an "Urgent Care" form for non-certified dentists who provide emergency care to Medicaid clients. Finally, the recently bid Medicaid fiscal agent contract will allow for several technical improvements, including eligibility verification via the Internet. The hope is that reducing administrative barriers to dentist participation will make oral health more available to Medicaid clients.

Managed Care: Dental services are reimbursed on a fee-for-service basis in all counties except for Milwaukee, Kenosha, Racine and Waukesha. In those four counties, dental care for Medicaid and BadgerCare recipients is provided through health maintenance organizations (HMOs).

Under the managed care contracts, HMOs are required to provide dental care within 90 days for a routine visit and within 24 hours for an emergency. The HMOs have contracted with two dental managed care organizations that then negotiate with individual dentists.

In managed care, HMOs are paid a monthly amount per person for every Medicaid or BadgerCare enrollee (capitation rate). In the fee-for-service system, individual dentists submit claims to, and are paid by, the Department's fiscal agent according to a set schedule of fees. In Fiscal Year 2003, total Wisconsin Medicaid/BadgerCare fee-for-service dental payments were \$26.36 million. Health Maintenance Organizations were paid \$9.9 million to provide dental services to recipients in Milwaukee, Waukesha, Racine, and Kenosha counties.

In Fiscal Year 2004, there were 609,862 fee-for-service Medicaid recipients in Wisconsin. Of these, 138,986, or 22.8 percent of the total, received dental services. The percentage of non-Medicaid individuals that access dental care each year ranges from 50 percent to 70 percent based on family income and private dental benefits available.

Medicaid Clients Receiving Dental Care Reimbursement

Currently, 412,806 children under the age of 21 are eligible for dental benefits under the fee for service or the managed care systems. Twenty percent of the fee-for-service dental population under the age of 21 receives preventative care. Less than ten percent are receiving restorative services under the fee-for-service Medicaid program.

Medicaid/BadgerCare recipients have many obstacles to maintaining quality oral health and to accessing dental care services, including:

- Low participation rate among dentists
- Very few dentists accepting new MA patients
- Long waiting lists
- Accessing dental services on emergency, rather than routine basis
- Poor oral hygiene and preventive care practices
- Dietary and lifestyle factors
- Lack of personal funds to pay privately for dental care
- Lack of oral health education
- No established relationships with dentists
- Transportation issues
- Shortage of dentists, particularly in rural areas and for special needs populations
- Lack of interpreter services

Medicaid Participation by Dentists

In 2004, 40 percent of Wisconsin licensed dentists (1,342) submitted a fee-for-service claim for Medicaid reimbursement. While some high-volume providers are increasing the number of patients served, small volume providers are static or decreasing. The capacity and geographic distribution of high volume providers is not adequate to meet the oral health needs in Wisconsin. More than 50 percent of certified dentists in Wisconsin submit less than 100 claims annually. In addition, most participating dentists are not accepting new patients.

Dentists cite several reasons for the low participation rates:

- Inadequate Medicaid reimbursement rates
- Burdensome Medicaid paperwork
- Complicated prior authorization processes
- Medicaid recipient behaviors

Volume of Claims Submitted by Wisconsin Medicaid-Certified Dentists*

Volume of Claims	Number of Medicaid-Certified Dentists					
	FY00		FY01		FY03	
1-49	653	45.3%	601	42.7%	548	39.8%
50-99	251	17.4%	231	16.4%	215	15.6%
100-249	292	20.3%	295	21%	301	21.9%
250-499	135	9.4%	153	10.9%	162	11.8%
500-749	53	3.7%	56	4%	55	4%
750-999	22	1.5%	31	2.2%	32	2.3%
1,000-1,999	30	2.1%	31	2.2%	49	3.6%
2,000 or more	2	0.3%	8	0.6%	15	1.1%

*Claims submitted by dentists, based on performing provider identification statistics.

In FY 00, 54.7% of participating Medicaid-certified dentists submitted 50 or more Medicaid claims.

In FY 01, 57.3% of participating Medicaid-certified dentists submitted 50 or more Medicaid claims.

In FY 03, 60.2% of participating Medicaid-certified dentists submitted 50 or more Medicaid claims.

GOVERNOR'S TASK FORCE TO IMPROVE ACCESS TO ORAL HEALTH

Since the Surgeon General's report was released in 2000, states have been experimenting with reforms to oral health delivery systems. These reforms include increasing dentist reimbursement rates, simplifying administrative tasks, educating Medicaid clients about the dental system and the importance of preventive care, expanding the scope of practice for dental hygienists, and creating loan forgiveness programs for dentists willing to take Medicaid patients or work in shortage areas.

There are many challenges involved with creating access to dental care but since dental disease is preventable, after the initial investment of treating existing disease, it is relatively inexpensive to maintain healthy teeth through education, appropriate use of fluorides, and regular oral hygiene. True prevention requires an understanding of the importance of oral health as well as access to dental health professionals.

In spite of the obstacles, the members of the Task Force to Improve Access to Oral Health worked diligently for eight months to identify innovative, viable, dynamic solutions to the access problem.

The following is a summary of their discussion and final recommendations on topics relating to improving access to oral health.

Dental Professionals Workforce Recruitment, Training and Loan Assistance

Wisconsin operates a Health Professions Loan Assistance Program through the Department of Commerce. The program provides for repayment of medical and school loans incurred by physicians, nurse practitioners, physician assistants, certified nurse midwives, dentists, and dental hygienists who agree to practice primary care in designated dental health professional shortage areas in Wisconsin.

Designed to provide incentives for health care providers to locate their practice in Wisconsin's rural and urban health professional shortage areas, the program provides dentists up to \$50,000 and dental hygienists up to \$25,000 in loan repayment over a three-year period.

During each of the three years of the award, dentists and dental hygienists must provide dental services in a federally designated shortage area to a certain minimum number of recipients of Medicaid or BadgerCare.

For awards partially funded by federal matching dollars, additional provisions apply, including: recipients must work in public or non-profit sites and recipients must accept Medicaid assignment and must utilize a sliding fee scale for those persons with incomes up to 200 percent of the federal poverty level.

The Task Force discussion focused on removing the requirement of practicing in a designated shortage area and tying loan assistance *only* to serving Medicaid and uninsured populations. Members pointed out that covering children in need was the priority, not location of the dentist or dental hygienist.

The Task Force heard a presentation from the Wisconsin Office of Rural Health (WORH). The WORH was established in 1975, within the University of Wisconsin's Medical School, to address shortages of health services in rural areas. As the WORH evolved, it developed a strong health professional recruitment program and worked with programs at the federal and state levels to bring health care services to underserved areas.

The WORH has recently expanded efforts to recruit oral health professionals to shortage areas. Their past efforts to recruit physicians have been successful.

Members also discussed existing public health education during dental school and the need for education in public health to continue after graduation.

The Task Force Recommends

1. The Task Force recommends continued or increased funding for the state's health care provider loan forgiveness programs and that the eligibility for the loans be linked to serving an unduplicated number Medicaid or BadgerCare recipients not to fall below a certain minimum amount of claims paid* or to serving in a dental health professional shortage area.

*The program requires a minimum of:

- 50 recipients served and \$8000 in claims paid during the first year of the award.
 - 70 recipients served and \$11,000 in claims paid the second year.
 - 90 recipients served and \$15,000 in claims paid the third year and continuing years.
2. Direct the Department of Commerce to work with the Rural Health Development Council to develop a dentist recruitment model and tools to be used in recruiting oral health professionals to rural and urban dental health professional shortage areas.
 3. The Task Force recommends that the Governor encourage the Wisconsin Dental Association to provide dental education at their annual sessions that would help general dentists become familiar with the care of children from 1 to 3 years of age.

Marquette University School of Dentistry

A Doctor of Dental Surgery (DDS) degree requires four years of dental school after completing an undergraduate program. The state's only dental school is the Marquette University School of Dentistry (Marquette). The dental school was built to accommodate 80 new students per year for a total of 320 students enrolled in the four-year program.

Marquette receives a subsidy (capitation) from the State of Wisconsin to provide a reduced level of tuition for a limited number of Wisconsin residents who attend this school. The capitation amount is currently \$8,753 per student with a limit of 160 Wisconsin residents covered per year (40 Wisconsin students per class). The 2003-05 Budget reduced the capitation amount per student from \$11,670.

**History of Higher Educational Aids Board
Capitation Payments for Wisconsin Student Tuition
To Marquette University School of Dentistry**

<u>Fiscal Year</u>	<u>Statutory Limit</u>	<u># of Students</u>
2000-01	\$1,167,000	100
2001-02	\$1,342,100	100
2002-03	\$1,517,100	113
2003-04	\$1,269,100	145
2004-05	\$1,400,400	160

Fifty Wisconsin applicants presently would qualify for admission into the dental school each year according to standards set by the school. Marquette has said that they will accept at least 50 Wisconsin dental applicants each year if the state increases the tuition assistance funding for an additional 10 residents.

The Task Force discussion centered on the number of Wisconsin applicants and on their post-graduate decisions to stay in Wisconsin or go elsewhere to practice. Task Force members decided that we have little control over new dentists' choices that are based on non-financial factors but that Wisconsin students were the most likely to stay in the state to practice upon graduation from dental school so this funding is important.

The Task Force recommends:

1. The Task Force recommends that the state increase the annual funding from the Higher Educational Aids Board to support annual capitation payments for 50 Wisconsin students in each future class at the Marquette University School of Dentistry. Funding would begin in the Fall 2006 semester. This is an increase of ten Wisconsin students per class.
2. The Task Force recommends that the state increase the tuition subsidy for Wisconsin residents who attend Marquette University School of Dentistry from \$8,753 to \$11,670 per year.

Dental Hygienist Workforce

According to the Department of Regulation and Licensing, there are 3,450 active, licensed dentists and 4,190 active, licensed dental hygienists in Wisconsin. According to a 2000 Dental Hygiene Workforce survey from the Dental Hygiene Association of Wisconsin, one out of four dental hygienists do not feel there are enough job opportunities for them in the dental field.

A dental hygienist must graduate from a program accredited by the American Dental Association Commission on Dental Accreditation, pass a written national examination and a practical clinical examination to become eligible for Wisconsin licensure. Dental hygiene is the performance of educational, preventive or therapeutic dental services as defined in the Wisconsin Statutes s. [447.01\(3\)](#). A dental hygienist may practice dental hygiene or perform remediable procedures as authorized by a dentist who is present in the facility or under a written or oral prescription from a dentist or in limited circumstances where a dentist is not present.

Ten of sixteen technical college districts in the Wisconsin Technical College System offer associate degree programs that prepare students to become dental hygienists. To achieve accreditation, the technical college program must meet certain standards that students will not graduate without training in:

- Providing dental hygiene care for the child, adolescent, adult and geriatric patient.
- Assessing the treatment needs of patients with special needs.

State statutes and administrative rules of the Dentistry Examining Board specify certain activities that a dental hygienist may legally perform while a dentist is present in the facility, practices that a dental hygienist may legally perform whether or not a dentist is present in the dental facility, and prohibited practices for dental hygienists.

The Task Force was presented with information on differing legal opinions on the activities that can be performed by a dental hygienist with and without the prescription or presence of a dentist. The Department of Regulation and Licensing received an opinion from the Attorney General's office stating that Wisconsin statutes "plainly delineate three circumstances where a dental hygienist may apply dental sealants or fluoride treatments without either the authorization or the presence of a dentist." (*See Appendix E*)

The discussion focused on venues where access could be improved if dental hygienists were allowed to practice more independently.

The Task Force recommends:

1. The Task Force recommends that Wisconsin State Statutes be amended to align the dental hygienist scope of practice with accreditation standards and to allow dental hygienists to practice independently under that legal scope of practice. Monica Hebl asked to be recorded voting no.
2. The Task Force recommends that the Governor assemble a study group to examine the feasibility of developing an advanced practice dental hygienist education program in Wisconsin. The group could include the Wisconsin Dental Association, the Dental Hygiene Association of Wisconsin, the Wisconsin Dental Hygiene Association, the Wisconsin Technical College System Dental Hygiene programs, the Marquette School of Dentistry, the University of Wisconsin System and other health providers.
3. The Task Force recommends that the Governor propose a state legislative initiative to expand a dentist's ability to delegate dentistry practices and procedures.

Community Water Fluoridation

Currently, approximately 70 percent of Wisconsin's population resides in areas with public water systems. Approximately 90 percent of this population residing on public water systems has optimally fluoridated water. This results in 63 percent of Wisconsin's total population receiving the benefits of appropriate levels of fluoride.

Communities interested in fluoridation of their water supply need to purchase equipment to fluoridate water at each system pump house, may need to construct additional building space to house the equipment, and need to provide funding for operations and maintenance staff. Current funding in Wisconsin for community fluoridation systems is limited to an allocation from the federal prevention block grant. The state provides \$3,500 annually from this federal block grant.

The Task Force recommends:

1. The Task Force recommends an increase in state funding available for communities to fluoridate their water supply. The Task Force recommends providing \$25,000 in annual, non-lapsing funding.

Medicaid Funding and System Changes

The Task Force members had many long discussions about the effect of Medicaid reimbursement rates on access to oral health and about the effectiveness of the HMO dental systems in four Southeastern Wisconsin counties.

Medicaid Reimbursement Rates

There was general agreement among the membership that reimbursement rates for dental services should be increased.

Several models were developed to show the fiscal effect of increases in the rate. One model would increase the rate by 10 percent each year of the biennium with the goal of rewarding participating dentists to continue their existing service to Medicaid clients. This model acknowledged the reality of the existing Medicaid deficit and improbability of appropriating millions of additional dollars in the existing fiscal environment.

One model would increase the rate to the 75th percentile with the goal of increasing the number of providers who would accept Medicaid clients under a higher reimbursement rate. The Wisconsin Dental Association advocated for funding at the 75th percentile based on their assertion that increasing the rates to that level has been successful in increasing access to dental care in other states and that small incremental increases would not be enough to attract more dentists to the Medicaid program.

Agreement could not be reached by the members on any of the presented models.

The Task Force recommends:

1. The Task Force recommends a \$20 million annual increase in state funding to increase the dental reimbursement rate and require that future investments in the dental Medicaid program include pay-for-performance strategies that assure increased access, regardless of the delivery system (i.e. whether services are delivered through fee-for-service or through HMOs).

2. The Task Force recommends the adoption of a tax on soda purchases (like the Two Cents for Tooth Sense plan) with the revenues going to the dental Medicaid program and other funding priorities as recommended by the Governor's Task Force to Improve Access to Oral Health.

HMO Dental Services

The Department of Health and Family Services began an extensive analysis of the performance of Wisconsin's various dental delivery systems in 2003. The Department analyzed a variety of data about dental care provided to HMO enrollees and compared it to Medicaid and BadgerCare fee-for-service clients. The analysis yielded the following conclusions:

- HMO-enrolled children were less likely to receive dental care than children receiving fee-for-service dental benefits in 2003. HMO-enrolled adults, by comparison, were more likely to receive dental care than their fee-for-service counterparts.
- Among clients receiving care, HMO enrollees received approximately the same number of dental services as fee-for-service clients.
- Pricing HMO-reported dental encounters at fee-for-service rates shows that if the services reported by the HMOs were provided in the fee-for-service system, the Department would have paid \$2.7 million less than it did for dental services provided by HMOs during SFY 2003.
- Delivery of preventive dental care by HMOs to children who have been enrolled in the same HMO for at least ten months has increased over the last several years, to levels exceeding those of the comparable fee-for-service population.
- HMO enrollees who receive dental services report high satisfaction with the service delivery system, and there is little evidence of unresolved grievances related to inability to access dental care.

Although the HMO delivery system is not yet operating at the level that the Department would desire, this system does show improvement, especially among continuously enrolled clients. In addition, the managed care model provides contractual guarantees that the Department can enforce to ensure that dental care will be provided patients in need of dental care will be provided that care.

Based on this analysis, the Department's Health Care Financing staff made the following recommendations for Medicaid dental administration:

- Emphasize that future investments in the Medicaid dental program should be spent in pay-for-performance strategies that assure increased access, regardless of the delivery system.
- Reform the HMO delivery system, and strengthen contractual guarantees not available in the current fee-for-service delivery system to improve the level of service provided to clients.
- Fully investigate the "carve-out" option, including the development of a request for information on a contract for statewide dental benefits administration.
- Support the efforts of the Governor's Task Force on Access to Oral Health Care.

The Task Force was most concerned 1) about children not having the same access to care that they would have under the fee-for-service model, 2) about the three tier system (HMO, Dental Administrator, and dentists) spending too much on administrative costs before the oral health provider received payment for care provided, and 3) about the complexity of the system which potentially leaves clients uncertain of whom to call when they cannot get an appointment.

Specifically, the members feel that the current complaint system is inadequate in determining if care levels and access requirements (90 days for non-emergency care and 24 hours for emergencies) are being met. While members were supportive of the access guarantees under managed care, the additional cost of these contracts was questioned due to uncertainty about clients' ability to get an appointment as required.

The Task Force recommends:

1. The Task Force recommends that the Department of Health and Family Services develop a request for information on a contract for a statewide dental benefits administrator. This "carve out" option would remove dental claims processing and customer service from both the state's current HMO and fee-for-service systems. The state would contract with a specialized dental benefits administrator for provision of these services and maintenance of a dental provider network. Ideally, the contract would include enforceable benchmarks regarding utilization and access targets, and expanded customer outreach and education requirements.
2. Under the current HMO dental delivery system, the Department of Health and Family Services would develop a complaint form for use by current HMO dental system patients who are unable to access dental care in the contractually required timeframe. The Department would share the form with HMO medical providers in the four-county region and would include information about who to contact when they are unable to access service within 90 days for non-urgent care and within 24 hours for urgent care. The form, once completed by the HMO client, would be sent to DHFS as a formal complaint regarding HMO access to dental care.

HealthCheck

Federal law entitles all children enrolled in Medicaid to coverage of any medically necessary dental services found as a result of a screening under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is the nation's primary source of well child care for low-income youths through age 20. HealthCheck is Wisconsin Medicaid's EPSDT Program.

The Task Force discussed discrepancies in the recommended age for the first EPSDT screening.

The Task Force recommends:

1. The Task Force recommends that the Department of Health and Family Services coordinate the Early and Periodic Screening, Detection, and Treatment (HealthCheck) periodicity schedule with the American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommendations which changes the age of the first screening from age 3 to age 1.

Shared Responsibility

The Task Force also had a presentation on the Children's Hospital of Milwaukee's Clear Path program that works to develop shared respect between dentists and Medicaid recipients. This education and awareness model is one example of programs that are being developed in other areas of the nation that asks families to understand the demands of a dentist's schedule and business at the same time as it makes dentists and their staff aware of the needs of poor and low-income families. Informal outcomes have shown increased access for families needing dental care and decreased no-show rates at appointments.

The Task Force recommends:

1. The Task Force recommends that the Governor explore the expansion of Clear Path with Children's Hospital of Milwaukee and the Greater Milwaukee Dental Association. Clear Path is the hospital's training program for individuals looking for access to dental care. Individuals that attend the training are guaranteed an appointment at the dental clinic within six weeks. The program helps the dentists understand the pressures of the families seeking care and helps the families understand how their actions affect the dentist, the office, and the care of all clients. Monica Hebl asked to be recorded voting no.
2. The Task Force recommends that the Department of Health and Family Services develop patient education materials and programs to encourage responsible use of health care systems for distribution or presentation to Medicaid enrollees. Materials should include education on the importance of keeping and showing up on time for appointments and on proper behavior in waiting rooms.
3. The Task Force recommends funding two pilot grant programs, based loosely on the Washington ABCD Kids Get Care program, across the state. The two-year grants would include annual funding for a case manager, a community educator, and materials and supplies.

To be eligible for the grants, a project would need to:

- Show proof of commitment from an adequate number of area dentists who agree to be providers under an enhanced Medicaid dental fee.
- Include at least one local government entity (required to gain eligibility for federal HCFA funds) willing to provide caseworkers to do outreach.
- Establish an oversight task force that includes at least one representative from an oral health or children's health advocate organization, local health department, the dental community, and a K-12 education and/or day care provider and/or a pre-school or HeadStart organization. Meetings must occur at least quarterly during the two-year grant process.
- Identify an organization willing to develop and deliver the program training.

Pilots would be selected on ability to provide care and prevention to a wide group of children and based on the program's ability to be used as a model for other areas of the state.

Dentists who wish to be licensed in Wisconsin must:

1. Submit an application.
2. Pay a fee.
3. Present evidence satisfactory to the board of having completed the educational requirements in s. 447.04(1) Stats.
4. Present verification of successful completion of a required examination, clinical/laboratory demonstrations, and ethics and jurisprudence training.
5. Complete any other requirement established by the Dentistry Examining Board by rule.

The Task Force discussed creating a pathway for qualified, foreign-trained dentists to gain licensure in Wisconsin. Currently the Dentistry Examining Board has not approved a foreign graduate evaluation program.

The members also discussed Wisconsin's current acceptance of only two of four available regional exams in the United States. The members were supportive of a national exam being available in the near future.

The Task Force recommends:

1. The Task Force recommends that current law be amended to provide that an applicant may pass any one of the four regional exams for Wisconsin licensure. When a national exam is approved, passage of that exam would also allow an applicant to receive licensure in Wisconsin upon completion of required testing and application. David Carroll asked to be recorded voting no.
2. The Task Force recommends that Wisconsin create a special training license available to foreign-trained dentists that would allow practice in an American Dental Education Association approved residency program leading to full licensure. The residency period would last a minimum of two years and could lead to full licensure. There would have to be a supervision requirement with endorsement for full licensure contingent on the supervisor attesting to competency. Licensure would also require passage of national boards, an approved exam, and Wisconsin's ethics and jurisprudence exam. David Carroll and Monica Hebl asked to be recorded voting no.
3. The Task Force recommends that Wisconsin allow licensure of a foreign-trained dentist that completed an American Dental Education Association approved 2-year residency training program in an approved United States accredited school. Also, the dentist must have been licensed by and practiced in another state. Licensure would also require passage of national boards, an approved exam, and Wisconsin's ethics and jurisprudence exam. David Carroll and Monica Hebl asked to be recorded voting no.

Oral Health Safety Net Program Funding

The Task Force discussed other providers in addition to private dentists that could help expand access to dental care for low-income clients in Wisconsin. (See Appendix H) These “safety net” clinics provide services to a population that otherwise may not have access to health care.

- Ten of the 15 Federally Qualified Health Centers (FQHCs) have on-site, comprehensive dental programs for low-income individuals. Federally Qualified Health Centers (FQHCs) provide primary and preventive health care services in medically underserved areas. They receive federal dollars to provide primary care to low income clients and receive reimbursement for reasonable costs related to serving Medicaid recipients.
- Seven of the 11 tribal clinics in Wisconsin have comprehensive dental services provided.
- Marquette University School of Dentistry operates several outreach clinics.
- The rural dental health program funds two clinics in Menomonie and Ladysmith in underserved areas of the state. These clinics provide regular and preventive dental care to low income populations.
- As part of its associate degree dental hygiene programs, the Wisconsin Technical College System provides dental hygiene prevention services at 11 of the 16 technical colleges. Three of the technical colleges use their dental facilities both to train dental hygienists and assistants and to provide services to low-income individuals.

The Task Force recommends:

1. The Governor's Task Force recommends that the Governor appoint an ongoing State Oral Health Council made up of a representative from the Legislature, an FQHC representative, a Wisconsin Dental Association designee, an advocate for Medicaid clients, a public health representative, and other dental care advocates. The council should reflect an urban/rural balance.

Initially, the council would define criteria for a pilot project that would award grants to programs that provide dental care to those unable to access oral health care in the current system (like community clinics, FQHC expansions, hospital clinics, etc.). Grants would be awarded based on the criteria determined. Continued funding would result from meeting outcomes defined in the initial criteria. The Task Force recommends allocation of \$200,000 in annual funding for this program.

Regional Oral Health Operations

Oral Health Consultant Contracts: Currently, the Department of Health and Family Services contracts with a Registered Dental Hygienist in all five DHFS regions across the state using a federal Health Resources and Services Administration grant. Regional Oral Health Consultants provide technical assistance for county level pre-school or school-aged surveys, school-based fluoride mouthrinse, dietary fluoride supplement, and school-based or community-based dental sealant program development, maternal and early childhood caries prevention programs, and SmileAbilities, a program for families with children with special health care needs. The current budget provides \$9,133 annually per region for these contracts.

Portable Dental Equipment: The cost of a full portable dental operatory (Procart 1- Model #2600, over head light, radiographic unit, patient chair, assistant stool, operator stool, statim, curing lights, and transport cases) is approximately \$20,000.

The Task Force discussed the additional training and program development that could be provided if each DHFS regional office was given a full-time oral health staff and the necessary tools.

The Task Force recommends:

1. The Task Force recommends that the state fund five regional oral health consultants at a full-time level.
2. The Task Force recommends funding portable equipment at each Department of Health and Family Services public health region to be used in school based and community oral health programs for restorative and prevention services.

Children with Special Health Care Needs and Targeted Case Management

Some children with severe oral health needs may be eligible for targeted case management services under the Wisconsin Children with Special Health Care Needs (CSHCN) program.

The CSHCN program is funded by the Maternal Child Health Title V Block Grant and serves approximately 274,000 Wisconsin children who have special health care needs as defined under the program. These children are birth to 21 years of age and have a long term, chronic physical, developmental, behavioral or emotional illness or condition. The illness or condition:

- Is severe enough to restrict growth, development or ability to engage in usual activities;
- Has been or is likely to be present or persist for 12 months to lifelong; and
- Is of sufficient complexity to require specialized health care, psychological or educational services of a type or amount beyond that required generally by children.

Examples: cerebral palsy, diabetes, autism, attention-deficit disorder and severe asthma.

Children in this program are eligible for Targeted Case Management, a Medicaid program. Case management services assist recipients and their families to gain access and to coordinate a full array of services, including medical, social, educational, and vocational. These case management services include assessment, case plan development, ongoing monitoring and service coordination.

The Task Force recommends:

1. The Task Force recommends that the Department of Health and Family Services send a notice to local health departments clarifying that children screened in public health programs with severe oral health needs and meeting certain criteria may be designated by the state as a Child with Special Health Care Needs. The child therefore may be eligible for Targeted Case Management services. Direct DHFS to monitor the utilization to determine if further policy development is necessary.

Advocacy, Education, School Based Initiatives, and Local Public Health

The Task Force members recognized their role as advocates for improved access to oral health – a role that did not start with their appointment to the Task Force and will not end with final recommendations being sent to the Governor.

Members also wanted to use their role as a Task Force to promote a greater understanding of oral health as a component of total health.

The Task Force had several discussions about the importance of educating parents and children about the importance of brushing and flossing, about what causes decay, and about the benefits of fluoride. All oral health contacts should include education, as well as care.

The Task Force reviewed information about local government collaborative efforts with area school districts to provide oral health services in schools. These programs exist to deliver screening and sealants using portable equipment. School-based programs eliminate many hurdles to oral health care such as lack of transportation, missed appointments, and language barriers

Members also discussed the benefits of having local dentists involved in community strategic plans on oral health.

The Task Force recommends:

1. The Task Force recommends that the state lobby our federal representatives in support of oral health funding and legislative initiatives.
2. The Task Force recommends that the Department of Health and Family Services take a more proactive role in informing pediatricians and family practitioners about integrating oral health into all health care practices.
3. The Task Force recommends that the Department of Public Instruction (DPI) investigate the possibility of including a question on oral health on the required state exams. DPI should work with the Department of Health and Family Services to implement an oral health curriculum and make it available to all state school districts with the goal of 20 percent participation by 2007.
4. The Task Force recommends that the state provide \$100,000 annually to fund 2-year pilot programs that coordinate local public health programs with school district dental programs. Grants would be awarded based on benefits of the initiative. Successful applicants would be required to provide local matching funds for the two years of the program.
5. The Task Force recommends that the Department of Health and Family Services work with local health departments to encourage at least one oral health consolidated contract objective.
6. The Task Force recommends that the Governor encourage the Wisconsin Dental Association, the Wisconsin Public Health Association, and the Wisconsin Association of Local Health Departments Board to help connect government health policy entities with practicing or retired dentists so together they can work on strategies to improve oral health in their communities.

RECOMMENDATIONS OF GOVERNOR DOYLE'S TASK FORCE TO IMPROVE ACCESS TO ORAL HEALTH

The following recommendations were adopted by the Governor's Task Force to Improve Access to Oral Health. The recommendations are not listed in priority order. Because tooth decay is preventable, we expect that these options for expanding capacity, improving coordination and prevention, and increasing the focus on education could result in real improvement in our citizens' oral health.

Before making any specific recommendations to the Governor, the Task Force members agreed that in order to succeed at improving access, there needs to be a financial commitment to oral health in the state.

Health Care Provider Loan Forgiveness Programs



The Task Force recommends continued or increased funding for the state's health care provider loan forgiveness programs and that the eligibility for the loans be linked to serving an unduplicated number of Medicaid or BadgerCare recipients not to fall below a certain minimum amount of claims paid* or to serving in a dental health professional shortage area.

*The program requires a minimum of:

- 50 recipients served and \$8000 in claims paid during the first year of the award.
- 70 recipients served and \$11,000 in claims paid the second year.
- 90 recipients served and \$15,000 in claims paid the third year and continuing years.

Marquette University School of Dentistry



The Task Force recommends that the state increase the annual funding from the Higher Educational Aids Board to support annual capitation payments for 50 Wisconsin students in each future class at the Marquette University School of Dentistry. This is an increase of 10 Wisconsin students per class. Funding would begin in the Fall 2006 semester.







	Current Cost	First Year Cost	Annual Cost
\$	160 Wisconsin students for \$1,400,480 annually	170 Wisconsin students for \$1,488,010.	200 Wisconsin students for \$1,750,600 annually.



The Task Force recommends that the state increase the tuition subsidy for Wisconsin residents who attend the Marquette School of Dentistry from \$8,753 to \$11,670 per year.

	Current Cost	Annual Cost	Adoption of both Recommendations
\$	160 Wisconsin students for \$1,400,480 annually	160 Wisconsin students for \$1,867,200	200 Wisconsin students at \$11,670 would cost \$2,334,000 annually

Oral Health Financial Priorities

	<p>Soda Tax: The Task Force recommends the adoption of a tax on soda purchases (like the <i>Two Cents for Tooth Sense</i> plan) with the revenues going to the dental Medicaid program and other funding priorities as recommended by the Governor’s Task Force to Improve Access to Oral Health.</p>	
	<p>Dental Medicaid Funding: The Task Force recommends a \$20 million annual increase in state funding to increase the dental reimbursement rate and require that future investments in the dental Medicaid program include pay-for-performance strategies that assure increased access, regardless of the delivery system (i.e. whether services are delivered through fee-for-service or through HMOs).</p>	\$20 million
	<p>Oral Health Pilots: The Task Force recommends funding two pilot grant programs, based loosely on the Washington ABCD Kids Get Care program, across the state. The two-year grants would include annual funding for a case manager, a community educator, and materials and supplies. To be eligible for the grants, a project would need to:</p> <ul style="list-style-type: none"> • Show proof of commitment from an adequate number of area dentists who agree to be providers under an enhanced Medicaid dental fee. • Include at least one local government entity (required to gain eligibility for federal HCFA funds) willing to provide caseworkers to do outreach. • Establish an oversight task force that includes at least one representative from an oral health or children’s health advocate organization, local health department, the dental community, and a K-12 education and/or day care provider and/or a pre-school or HeadStart organization. Meetings must occur at least quarterly during the two-year grant process. • An organization willing to develop and deliver the program training. 	\$200,000
	<p>Pilots would be selected on ability to provide care and prevention to a wide group of children and based on the program’s ability to be used as a model for other areas of the state.</p>	
	<p>Regional Oral Health Staff: The Task Force recommends that the state fund five regional oral health consultants at a full-time level.</p>	\$240,000
	<p>Regional Portable Equipment: The Task Force recommends funding portable equipment at each Department of Health and Family Services public health region to be used in school based and community oral health programs for restorative and prevention services.</p>	\$100,000 <i>One time cost</i>
	<p>Community Water Fluoridation: The Task Force recommends an increase in state funding available for communities to fluoridate their water supply. The Task Force recommends providing \$25,000 in annual, non-lapsing funding.</p>	\$25,000

Dental Hygienist Workforce



The Task Force recommends that Wisconsin State Statutes be amended to align the dental hygienist scope of practice with accreditation standards and to allow dental hygienists to practice independently under that legal scope of practice.

HMO Dental Services System



The Task Force recommends that the Department of Health and Family Services develop a request for information on a contract for a statewide dental benefits administrator. This “carve out” option would remove dental claims processing and customer service from both the state’s current HMO and fee-for-service systems. The recommendation is that the state would contract with a specialized dental benefits administrator for provision of these services and maintenance of a dental provider network. Ideally, the contracts would include enforceable benchmarks regarding utilization and access targets, and expanded customer outreach and education requirements.



The Task Force recommends that, under the current HMO dental delivery system, the Department of Health and Family Services should develop a complaint form for use by current HMO dental system patients who are unable to access dental care in the contractually required timeframe. The form would be shared with HMO medical providers in the four-county region and should include information about who to contact when they are unable to access service within 90 days for non-urgent care and within 24 hours for urgent care. The form, once completed by the HMO client, would be sent to DHFS as a formal complaint regarding HMO access to dental care.

Dental Licensure



The Task Force recommends that current law be amended to provide that an applicant may pass any one of the four regional exams for Wisconsin licensure. When a national exam is approved, passage of that exam would also allow an applicant to receive licensure in Wisconsin upon completion of required testing and application.



The Task Force recommends that Wisconsin create a special training license available to foreign-trained dentists that would allow practice in an American Dental Education Association approved residency program leading to full licensure. The residency period would last a minimum of two years and could lead to full licensure. There should be a supervision requirement with endorsement for full licensure contingent on the supervisor attesting to competency. Licensure would also require passage of national boards, an approved exam and Wisconsin’s ethics and jurisprudence exam.



The Task Force recommends that Wisconsin allow licensure of a foreign-trained dentist that completed an American Dental Education Association approved 2-year residency training program in an approved United States accredited school. Also, the dentist must have been licensed by and practiced in another state. Licensure would also require passage of national boards, an approved exam and Wisconsin’s ethics and jurisprudence exam.

School Based Oral Health and Oral Health Education



The Task Force recommends that the Department of Public Instruction (DPI) investigate the possibility of including a question on oral health on the required state exams. DPI should work with the Department of Health and Family Services to implement an oral health curriculum and make it available to all state school districts with the goal of 20 percent participation by 2007.



The Task Force recommends that the state provide \$100,000 annually to fund two-year pilot programs that coordinate local public health programs with school district dental programs. Grants would be awarded based on benefits of the initiative. Successful applicants would be required to provide local matching funds for the two years of the program.

Oral Health Safety Net Program Funding



The Governor's Task Force recommends that the Governor appoint an ongoing State Oral Health Council made up of a representative from the Legislature, an FQHC representative, a Wisconsin Dental Association designee, an advocate for Medicaid clients, a public health representative, and other dental care advocates. The council should reflect an urban/rural balance.

Initially, the council would define criteria for a pilot project that will award grants to programs that provide dental care to those unable to access oral health care in the current system (like community clinics, FQHC expansions, hospital clinics, etc.). Grants would be awarded based on the criteria determined. Continued funding would result from meeting outcomes defined in the initial criteria. The Task Force recommends allocation of \$200,000 in annual funding for this program.

Actions by the Department of Health and Family Services



The Task Force recommends the following actions by the Department of Health and Family Services:

- Develop patient education materials and programs to encourage responsible use of health care systems for distribution or presentation to Medicaid enrollees. Materials should include education on the importance of keeping and showing up on time for appointments and on proper behavior in waiting rooms.
- Coordinate the Early and Periodic Screening, Detection, and Treatment (HealthCheck) periodicity schedule with the American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommendations which changes the age of the first screening from age 3 to age 1.
- Take a more proactive role in informing pediatricians and family practitioners about integrating oral health into all health care practices.
- Work with local health departments to encourage at least one oral health consolidated contract objective.

Actions by the Department of Health and Family Services (continued)

- Send a notice to local health departments clarifying that children screened in public health programs with severe oral health needs and meeting certain criteria may be designated by the state as a Child with Special Health Care Needs. The child therefore may be eligible for Targeted Case Management services. Direct DHFS to monitor the utilization to determine if further policy development is necessary.

Further Actions



The Task Force recommends the following actions by the Governor:

- Direct the Department of Commerce to work with the Rural Health Development Council to develop a dentist recruitment model and tools to be used in recruiting oral health professionals to rural and urban dental health professional shortage areas.
- Encourage the Wisconsin Dental Association to provide dental education at their annual sessions that would help general dentists become familiar with the care of children from 1 to 3 years of age.
- Assemble a study group to examine the feasibility of developing an advanced practice dental hygienist education program in Wisconsin. The group could include the Wisconsin Dental Association, the Dental Hygiene Association of Wisconsin, the Wisconsin Dental Hygiene Association, the Wisconsin Technical College System Dental Hygiene programs, the Marquette School of Dentistry, the University of Wisconsin System and other health providers.
- Explore the expansion of Clear Path with Children's Hospital of Milwaukee and the Greater Milwaukee Dental Association. Clear Path is the hospital's training program for individuals looking for access to dental care. Individuals that attend the training are guaranteed an appointment at the dental clinic within six weeks. The program helps the dentists understand the pressures of the families seeking care and helps the families understand how their actions affect the dentist, the office, and the care of all clients.
- Encourage the Wisconsin Dental Association, the Wisconsin Public Health Association and the Wisconsin Association of Local Health Departments Board to help connect government health policy entities with practicing or retired dentists so together they can work on strategies to improve oral health in their communities.
- Lobby our federal representatives in support of oral health funding and legislative initiatives.
- Propose a state legislative initiative to expand a dentist's ability to delegate dentistry practices and procedures.

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APPENDIX A --- SUMMARY OF PUBLIC HEARING

At the Public Hearing on May 13, 2005, thirteen people testified before the Task Force members. Testimony from an additional 26 individuals and organizations was presented in writing to the members.

Persons testifying represented dentists, dental hygienists, and community and public health programs.

Supporters of increased reimbursement for dentists serving Medicaid clients stressed the need for making oral health a financial priority in Wisconsin. That financial commitment includes an increase in the number of covered Wisconsin students and in support for Marquette University School of Dentistry.

Opposition to the existing method of providing funding to the dental school was based on the fact that there are no assurances that the Wisconsin students would practice in Wisconsin.

A large share of the testimony focused on independent practice for dental hygienists. Supporters highlighted the importance of dental hygienists in providing preventive care and oral health education. Supporters stated that dental hygienist's training is currently under-utilized in Wisconsin so the recommendations made by this Task Force could have a great impact in promoting oral health. Many stressed the importance of their efforts to screen children for dental caries in settings such as schools, Head Start programs, and day cares.

Opponents of the recommendations made by the Task Force testified that dental hygienists are not qualified to provide oral diagnosis or restorative care, especially for the unique oral health care needs of Medicaid clients. They also pointed out that the independent practice of dental hygiene would not be economically viable and thereby would not ease the access problems in Wisconsin. Opponents noted that dental care is a team effort and only through the combination of prevention, education and restoration can a patient be restored to health.

Supporters of providing a more reasonable avenue for foreign trained dentists to receive licensure in Wisconsin testified that we are missing opportunities to hire qualified dentists who wish to practice in Wisconsin. Opponents point to the risks of licensing unqualified candidates.

All written testimony is available online at http://dhfs.wisconsin.gov/health/Oral_Health/taskforce/index.htm

APPENDIX B --- LIST OF INDIVIDUALS WHO TESTIFIED

Eric teDuits, Children Dental Center of Madison
Eva Dahl, Wisconsin Dental Association
John Bartkowski, Sixteenth Street Community Health Center
Ned Murphy, Wisconsin Dental Association
Nicolet DeRose, Wisconsin Dental Association
Karen Ordians, Children's Health Alliance of Wisconsin
Kate Venne, AIDS Resource Center of Wisconsin
Emily Kinsell Berger, Wisconsin Dental Hygienists' Association
Kathleen Endres, Dental Hygiene Association of Wisconsin
Anne Hvizdak, Healthy Smiles for Portage and Wood County
Tammy Filipiak
Lori Dille, Southwestern Wisconsin Community Action Program, Inc.
Jeff Moos, Midwest Dental

Submitted Written Testimony:

Mary Czech-Mrochinski, Marquette University
Shirley Gutkowski
Susan Klemm
The Brown County Oral Health Partnership
Marilyn Beck
Nancy Rublee
Teryl Frosch
Rhonda Akeson
Pamela Prenger
Kathy Williams
Tresa Kronberger
Brenda Heiser
Debbie Stieve
Wendy Ruesch
Sharon Haugerud, Rural Health Dental Clinic and the Dunn County Oral Health Coalition
Dawn Peetz
Beth Satchell
Faye Tetzloff
Angie Zunker
Suzanne Tack
Cristine Smith
Edward Dorff, Howe Elementary – Green Bay Area Public Schools
Tracy Ellis, Price County Health Department
Marsha Siik, Wisconsin Office of Rural Health, Dentist Placement Program
Marsha Alt
Gerry Born, Wisconsin Council on Developmental Disabilities

APPENDIX C --- RECOMMENDATIONS THAT REQUIRE LEGISLATION



Health Care Provider Loan Forgiveness Programs: The Task Force recommends continued or increased funding for the state's health care provider loan forgiveness programs and that the eligibility for the loans be linked to serving an unduplicated number of Medicaid or BadgerCare recipients not to fall below a certain minimum amount of claims paid or to serving in a dental health professional shortage area.



Wisconsin Residents at Marquette Dental School: The Task Force recommends that the state increase the annual funding from the Higher Educational Aids Board to support annual capitation payments for 50 Wisconsin students in each future class at the Marquette University School of Dentistry. Funding would begin in the Fall 2006 semester.



Marquette Dental School Subsidy for Wisconsin Students: The Task Force recommends that the state increase the tuition subsidy for Wisconsin residents who attend the Marquette School of Dentistry from \$8,753 to \$11,670 per year.



Soda Tax: The Task Force recommends the adoption of a tax on soda purchases (like the *Two Cents for Tooth Sense* plan) with the revenues going to the dental Medicaid program and other funding priorities as recommended by the Governor's Task Force to Improve Access to Oral Health.



Dental Medicaid Funding: The Task Force recommends a \$20 million annual increase in state funding to increase the dental reimbursement rate and require that future investments in the dental Medicaid program include pay-for-performance strategies that assure increased access, regardless of the delivery system (i.e. whether services are delivered through fee-for-service or through HMOs).



Dental Hygienist Workforce: The Task Force recommends that Wisconsin State Statutes be amended to align the dental hygienist scope of practice with accreditation standards and to allow dental hygienists to practice independently under that legal scope of practice.



* Regional Exams: The Task Force recommends that current law be amended to provide that an applicant may pass any one of the four regional exams for Wisconsin licensure. When a national exam is approved, passage of that exam would also allow an applicant to receive licensure in Wisconsin upon completion of required testing and application.



* Foreign-Trained Dentist Residency Program: The Task Force recommends that Wisconsin create a special training license available to foreign-trained dentists that would allow practice in an American Dental Education Association approved residency program leading to full licensure. The residency period would last a minimum of two years and could lead to full licensure. There should be a supervision requirement with endorsement for full licensure contingent on the supervisor attesting to competency. Licensure would also require passage of national boards, an approved exam, and Wisconsin's ethics and jurisprudence exam.

Recommendations Requiring Legislation (Continued)



* Foreign-Trained Dentist Licensure: The Task Force recommends that Wisconsin allow licensure of a foreign-trained dentist that completed an American Dental Education Association approved 2-year residency training program in an approved United States accredited school. Also, the dentist must have been licensed by and practiced in another state. Licensure would also require passage of national boards, an approved exam, and Wisconsin's ethics and jurisprudence exam.



Dental Delegation: Propose a state legislative initiative to expand a dentist's ability to delegate dentistry practices and procedures.



* EPSDT Periodicity Schedule: Coordinate the Early and Periodic Screening, Detection, and Treatment (HealthCheck) periodicity schedule with the American Academy of Pediatric Dentistry and the American Academy of Pediatrics recommendations which changes the age of the first screening from age 3 to age 1.



Community Water Fluoridation: The Task Force recommends an increase in state funding available for communities to fluoridate their water supply. The Task Force recommends providing \$25,000 in annual, non-lapsing funding.

May be Enacted as Legislation



Pilot program recommendations from the Task Force could be enacted through legislation or by using grant funds received from federal or private organizations.

- Oral Health pilots based on the Washington ABCD Kids Get Care program,
- School-Based program pilots,
- Safety net clinic pilots.










Regional portable equipment could be purchased as directed in legislation or using funds received from federal or private organizations.






Regional oral health staff hours could be increased as directed in legislation or using funds received from federal or private organizations.

** May be accomplished using legislation or the rule making process.*

APPENDIX D --- RECOMMENDATIONS WITH A FISCAL EFFECT

	<u>Annual Cost State Funds</u>
 <p>Wisconsin Residents at Marquette Dental School: The Task Force recommends that the state increase the annual funding from the Higher Educational Aids Board to support annual capitation payments for 50 Wisconsin students in each future class at the Marquette University School of Dentistry. Funding would begin in the Fall 2006 semester.</p>	\$1,750,600*
 <p>Marquette Dental School Subsidy for Wisconsin Students: The Task Force recommends that the state increase the tuition subsidy for Wisconsin residents who attend the Marquette School of Dentistry from \$8,753 to \$11,670 per year.</p>	\$1,867,200**
 <p>Soda Tax: The Task Force recommends the adoption of a tax on soda purchases (like the <i>Two Cents for Tooth Sense</i> plan) with the revenues going to the dental Medicaid program and other funding priorities as recommended by the Governor's Task Force to Improve Access to Oral Health.</p>	
 <p>Dental Medicaid Funding: The Task Force recommends a \$20 million annual increase in state funding to increase the dental reimbursement rate and require that future investments in the dental Medicaid program include pay-for-performance strategies that assure increased access, regardless of the delivery system (i.e. whether services are delivered through fee-for-service or through HMOs).</p>	\$20 million
 <p>Oral Health Pilots: The Task Force recommends funding two pilot grant programs, based loosely on the Washington ABCD Kids Get Care program, across the state. The two-year grants would include annual funding for a case manager, a community educator, and materials and supplies.</p> <p>Pilots would be selected on ability to provide care and prevention to a wide group of children and based on the program's ability to be used as a model for other areas of the state.</p>	\$200,000
 <p>Regional Oral Health Staff: The Task Force recommends that the state fund five regional oral health consultants at a full-time level.</p>	\$240,000
 <p>Regional Portable Equipment: The Task Force recommends funding portable equipment at each Department of Health and Family Services public health region to be used in school based and community oral health programs for restorative and prevention services.</p>	\$100,000 ***

Fiscal Recommendations (Continued)

	Community Water Fluoridation: The Task Force recommends an increase in state funding available for communities to fluoridate their water supply. The Task Force recommends providing \$25,000 in annual, non-lapsing funding.	\$25,000
	School-Based Oral Health Pilot: The Task Force recommends that the state provide \$100,000 annually to fund two-year pilot programs that coordinate local public health programs with school district dental programs. Grants would be awarded based on benefits of the initiative. Successful applicants would be required to provide local matching funds for the two years of the program.	\$100,000
	Oral Health Safety Net Program Pilot: The Governor's Task Force recommends that the Governor appoint an ongoing State Oral Health Council to define criteria for a pilot project that would award grants to programs that provide dental care to those unable to access oral health care in the current system (like community clinics, FQHC expansions, hospital clinics, etc.). Grants would be awarded based on the criteria determined. Continued funding would result from meeting outcomes defined in the initial criteria.	\$200,000

** Upon attainment of 200 Wisconsin students at current per-student subsidy level.*

*** Assuming existing 40 Wisconsin students per year.*

**** One time cost.*

APPENDIX E --- ATTORNEY GENERAL'S OPINION



STATE OF WISCONSIN
DEPARTMENT OF JUSTICE

PEGGY A. LAUTENSCHLAGER
ATTORNEY GENERAL

Daniel P. Bach
Deputy Attorney General

17 W. Main Street
P.O. Box 7857
Madison, WI 53707-7857
www.doj.state.wi.us

Thomas Balistreri
Assistant Attorney General
balistreritj@doj.state.wi.us
608/266-1523
FAX 608/267-2223

December 9, 2004

Mr. Steven M. Gloe
General Counsel
Department of Regulation and Licensing
1400 East Washington Avenue
Madison, WI 53702

Dear Mr. Gloe:

You have asked the Attorney General's Office to comment on the circumstances in which a dental hygienist may apply dental sealants and fluoride treatments without a dentist authorizing or being present to supervise these procedures. We agree with your memorandum of October 19, 2004, and the memorandum of Daniel D. Stier, Chief Counsel of DHFS, dated April 1, 2004, regarding the circumstances in which a hygienist may independently provide these services.

Whether the application of dental sealants or fluoride treatments must be authorized or supervised by a dentist who is present on the premises depends primarily on where the hygienist provides these services.

The application of both dental sealants and fluoride treatments constitutes the practice of dental hygiene. The application of sealants is expressly defined as the practice of dental hygiene by Wis. Stat. § 447.01(3)(c) (2001-02). The application of fluoride has been added to the list of activities constituting the practice of dental hygiene by Wis. Admin. Code § DE 3-01(2)(e) (2000), under the authority granted to the Dentistry Examining Board by Wis. Stat. §§ 447.01(3)(g) and 447.02(1)(d) (2001-02).

A hygienist may ordinarily practice dental hygiene in a dental office, for a hospital or correctional facility, for a charitable institution, for a home health care agency, or for a dental care program for economically disadvantaged people only as authorized by a dentist who is present in the facility where the procedures constituting the practice of dental hygiene are performed. Wis. Stat. § 447.06(2)(a) and (b) (2001-02).

There are no such restrictions on the practice of dental hygiene for public and private schools, for dental schools or for local health departments. *See id.* So a hygienist may apply sealants or fluoride in these circumstances without the authorization or presence of a dentist. If a

Mr. Steven M. Gloe
December 9, 2004
Page 2

type of fluoride is used which is available only by prescription, however, it will have to be obtained under a prescription written by someone other than a hygienist who is legally authorized to prescribe controlled substances. *See* Wis. Stat. § 447.06(2)(d).

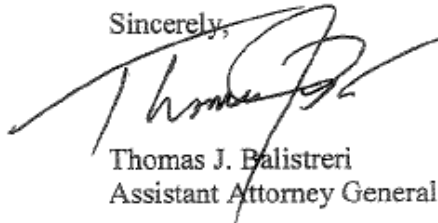
Moreover, even in the circumstances where dental hygiene must ordinarily be practiced in the presence of a dentist, a hygienist may apply sealants or fluoride without a dentist being present if these procedures are specifically prescribed orally or in writing by a dentist who has examined the patient within the preceding year, the patient knowingly consents, and, when the procedures are performed in a dental office, the patient has been a patient of the dentist for at least six months. Wis. Stat. § 447.06(2)(c).

An administrative rule of the Dentistry Examining Board appears to impose stricter requirements than the statutes regulating the practice of dental hygiene, providing that a "dental hygienist shall practice under the supervision of a licensed dentist in a dental facility or a facility specified in s. 447.08(4), Stats., if applicable." Wis. Admin. Code § DE 3.01.

However, Wis. Stat. § 447.08 can never be applicable because it has been repealed. 1989 Wisconsin Act 349, § 28. And to the extent that the remainder of the rule may be inconsistent with present Wis. Stat. § 447.06, it would be invalid because an administrative agency cannot promulgate a rule which is inconsistent with an unambiguous statute. *Chvala v. Bubolz*, 204 Wis. 2d 82, 89, 522 N.W.2d 892 (Ct. App. 1996). This is not to say that the rule is invalid since it would be subject to a construction which could resolve any apparent difference with the statute, which in any case is controlling.

In sum, the statutes plainly delineate three circumstances where a dental hygienist may apply dental sealants or fluoride treatments without either the authorization or the presence of a dentist. There are other circumstances where a dental hygienist may apply dental sealants or fluoride treatments with the authorization but without the presence of a dentist.

Sincerely,



Thomas J. Balistreri
Assistant Attorney General

TJB:ajw

balistreritj@mail.tickets/gloe, steven re dental hygienists applying sealants and fluoride.doc

APPENDIX F --- LEGISLATIVE PROPOSAL ON DENTAL HYGIENE

2005 - 2006 LEGISLATURE

LRB-2733/1

PJH:kjfrs

2005 BILL

1 AN ACT *to repeal* 447.06 (2) (a) 1., 2., 3., 4., 5., 6., 7. and 8., 447.06 (2) (b) and
2 447.06 (2) (c); *to renumber and amend* 447.06 (2) (a) (intro.); and *to amend*
3 447.01 (3) (d) of the statutes; **relating to:** dental hygienists.

Analysis by the Legislative Reference Bureau

Under current law, a licensed dental hygienist may perform dental hygiene only as an employee or as an independent contractor, and only in certain locations, such as a dental office, a school facility, a local health department, or for certain charitable or nonprofit dental care facilities. Current law requires a licensed dentist to be present at most of the facilities where the hygienist performs dental hygiene, unless certain conditions are met. This bill allows a dental hygienist to perform dental hygiene as a volunteer, an employee, or an independent contractor and removes the references to the specific locations at which the dental hygienist may perform. In addition, this bill eliminates the requirement that a dentist be present when a hygienist performs dental hygiene.

Current law also provides that a licensed dental hygienist may perform certain duties, including preparing a patient's case history or recording of clinical findings. This bill allows a licensed dental hygienist to present a patient's case history or recording of clinical findings to the patient.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

APPENDIX G --- PREVENTION AND RESTORATIVE PROGRAMS

Wisconsin has several state and federally funded programs that provide preventive dental services.

- **Community Water Fluoridation** is in effect in 283 systems. The program benefits 90 percent of the people on public water systems, but only 63 percent of the general population. It is funded in part from the federal Prevention Block Grant and in part from local taxes.
- **School-based Fluoride Mouth Rinse Program** provides school-based fluoride mouthrinsing programs to an estimated 10,023 children. It is funded by a state grant of \$25,000 GPR. In FY 01, requests for funding exceeded available funds.
- The **GuardCare** program provides medical clinical services for adults and children and dental clinical services for children for one week each year in underserved areas of the state. Members of the Wisconsin Army National Guard and other volunteers provide clinical services.
- The **Dietary Fluoride Supplement Program** provides supplements to an estimated 2,245 children. The program is funded by \$25,000 GPR through a grant program.
- **Healthy Smiles for Wisconsin (Seal a Smile)** screened 4,255 children in FY 03-04 and provided 12,344 dental sealants to 2,898 of them. The program is funded by \$60,000 GPR in grants available to communities. The Department received requests in excess of \$100,000 for this program.
- **Spit Tobacco Programs** provided a curriculum on tobacco avoidance to approximately 200 schools, for the use of a target population of 80,000 fifth graders. The program was funded by a grant from the Wisconsin Tobacco Control Board and is now funded through DHFS.
- **Medical Assistance** will cover prescriptions for fluoride drops or tablets for children whose water systems are not fluoridated. This can be supplied in a well-baby checkup.
- The federal and state government funds 14 **Federally Qualified Health Centers (FQHCs)**, which provide health and, in some cases, dental services to low-income populations. The state allocates \$3 million GPR annually to the FQHCs plus provides MA reimbursement. At least seven of these community health care centers use some of their state allocation to fund a dental program. Some of these clinics have six months waiting lists for dental services.
- The Department and its Medicaid HMO partners are conducting the **Healthy Teeth for Mom and Me** program, which seeks to integrate oral health care into the pre-natal and post-natal medical regimen of Medicaid-enrolled pregnant women in Milwaukee. The program operates under a grant from the federal Health Resources Services Administration.

- The **Maternal and Child Health (MCH) Block Grant** provides \$12,000 for school-based sealants.
- In past state budgets, GPR funds have been allocated to clinics that provide care in underserved areas of the state, for example, the **dental clinics in Ladysmith and Menomonie**. These clinics provide restorative and preventive dental care to low income populations. The 2005-07 will also allocate funds to clinics for the underserved.
- The Department provides \$2.8 million GPR to **Marquette University School of Dentistry** to provide clinic services and student clinical practicums to increase access to dental services for underserved populations. The grant gives dental students treatment experience with traditionally underserved populations and Medicaid recipients.
- The Department provides \$40,000 GPR annually to the Wisconsin Dental Association to administer the **Donated Dental Services Program**, under which volunteer dentists provide dental care to low-income individuals at no charge. The funding supports program expenses.
- The Department provides \$60,500 GPR annually to the **Marquette School of Dentistry Johnston Community Health Center Pediatric Dentistry Program**. This program helps support clinical dental services for children at the Johnston Community Health Center and also provides dental sealants to underserved children in elementary schools in Milwaukee. The primary target population for these funds is Hispanic children.
- **Regional Oral Health Consultants** are responsible for data collection and oral health prevention program development across Wisconsin. In 2003 they provided technical assistance to medical clinics and health departments, training over 175 physicians and nurses to integrate oral health measures into healthcare practice. Consultants are funded by a federal HRSA grant.
- **Wisconsin Oral Health Data Collection Plan**, monitors oral health status by Department of Health and Family Services Region and Statewide. Surveys should be repeated every three to five years.
- **Healthy Smiles for Head Start**, a survey of 456 children (aged 3-6 years) enrolled in Head Start, was conducted in 2003 to determine oral health status.
- The **Make Your Smile Count Survey** of children enrolled in third grade, assesses the need for oral health treatment among children in Wisconsin. The survey screened 3,307 third grade children in 2001 and will be repeated in 2006.
- The **Beyond Lip Service Grant Program** helps local health departments implement community water fluoridation; fluoride mouth rinse, varnish or supplement programs; and data collection programs. This three year grant, started in 2005, was funded at \$150,000 per year by the Wisconsin Partnership Fund for a Healthy Future.

APPENDIX H --- STATE, FEDERAL, AND TRIBAL DENTAL CLINICS

Federally Qualified Health Center Dental Service Sites

1. Scenic Bluffs Community Health Centers (Cashton/LaCrosse)
2. Family Health / La Clinica (Wautoma)
3. Family Health Center of Marshfield Family Dental Clinic (Marshfield/Ladysmith)
4. Bridge Community Health Clinic (Wausau)
5. Northern Health Centers, Inc. (Lakewood)
6. Beloit Area Community Health Center (Beloit)
7. Kenosha Community Health Center (Kenosha)
8. Milwaukee Health Services, Inc. (Milwaukee)
9. Sixteenth Street Community Health Center (Milwaukee)
10. Madison Community Health Center (Madison)

Wisconsin Technical College System Dental Hygiene Programs

1. Blackhawk (Janesville)
2. Chippewa Valley (Eau Claire)
3. Fox Valley (Appleton)
4. Lakeshore (Cleveland)
5. Madison Area (Madison)
6. Milwaukee Area (Milwaukee)
7. Northcentral (Wausau)
8. Northeast Wisconsin (Green Bay)
9. Waukesha County (Waukesha)
10. Western Wisconsin (LaCrosse)

Great Lakes Intertribal Dental Clinics

1. Forest County Potawatomi Health and Wellness Center (Crandon)
2. Ho-Chunk Nation Health Department (Black River Falls)
3. Lac Courte Oreilles Community Health Center (Hayward)
4. Menominee Tribal Clinic (Keshena)
5. Oneida Community Health Center (Oneida)
6. Peter Christensen Health Center (Lac du Flambeau)
7. Red Cliff Community Health Center (Bayfield)
8. Saint Croix Tribal Health Center (Webster)
9. Stockbridge-Munsee Health & Wellness Center (Bowler)

State Rural Health Dental Clinics

1. CESA 11 State Rural Health Dental Clinic Sites
 - Chippewa Valley Technical College (Menomonie)
 - St Joseph's Hospital (Chippewa Falls)
 - Sawyer County Health Department (Hayward)
 - Turtle Lake Dental Clinic (Turtle Lake)
2. Marshfield-Ladysmith Family Dental Clinic

Other Oral Health Providers

1. Office of Rural Health Outreach Grant: Mobile clinic rotates to Antigo (Langlade County), Merrill (Lincoln County), Rhinelander (Oneida County), and Laona (Forest County).
2. Marquette University School of Dentistry Services: The state provides funding for patient care provided at the Isaac Coggs Community Health Center, Johnston Community Health Center, St. Luke's Medical Center, Elder Care of Dane County, and the Tri County Community Dental Clinic, in Appleton.
3. Donated Dental Services: Volunteer WDA member dentists serve disabled, medically compromised and aged residents with this program. The program coordinator is funded with State GPR funds at the Wisconsin Dental Association.
4. Madre Angela Clinic – Milwaukee
5. Max W. Pohle Dental Clinic – Meriter Hospital, Madison
6. South Side Guadalupe Dental Clinic, Inc. - Milwaukee
7. Ministry Dental Clinic – Steven's Point
8. AIDS Resource Center of Wisconsin Dental Clinic (Milwaukee)

For more information about the oral health programs in Wisconsin, contact:

Department of Health and Family Services

Wisconsin Oral Health Program
PO Box 2659
Madison, WI 53701-2659
http://dhfs.wisconsin.gov/health/Oral_Health/

Warren LeMay, DDS, MPH
Chief Dental Officer
E-mail: lemaywr@dhfs.state.wi.us
Phone: 608-266-5152
Fax: (608) 267-8925

Nancy McKenney, RDH, MS
Chief Dental Hygiene Officer
E-mail: mckennr@dhfs.state.wi.us
Phone: (608) 266-3201
Fax: (608) 267-3824

For more information about the dental Medicaid financing, contact:

Department of Health and Family Services

Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Robert Dwyer, DDS
Chief Medical Officer
E-mail: dwyerra@dhfs.state.wi.us
Phone: 608-264-6754
Fax: 608-267-3380

Andrew Snyder, MPA
Dental Policy Analyst
E-mail: snydea@dhfs.state.wi.us
Phone: 608-266-9749
Fax: 608-266-1096