NC INSTITUTE OF MEDICINE
TASK FORCE ON DENTAL CARE ACCESS
REPORT TO THE 2000 NC GENERAL ASSEMBLY

NORTH CAROLINA INSTITUTE OF MEDICINE
CITIZENS DEDICATED TO IMPROVING THE HEALTH OF NORTH CAROLINIANS

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BACKGROUND

In April 1999, the Task Force on Dental Care Access of the NC Institute of Medicine, issued a report to the NC General Assembly and to the Secretary of the NC Department of Health and Human Services. The report described the difficulties many low-income Medicaid or uninsured individuals and families experience in accessing dental services. The report highlighted that overall only 20% of Medicaid recipients visited the dentist in SFY 1998. Young children were the least likely to visit a dentist—only 12.2% of children ages 1-5 visited a dentist that year. Since the Task Force report, there has been a slight improvement in utilization of dental services. Between March 1999 and March 2000, average monthly recipients increased 5.3% (Perruzzi, 2000).

There are a number of reasons for the low utilization of dental services among North Carolina Medicaid recipients. One primary reason is the difficulty Medicaid recipients face in finding a dentist willing to accept Medicaid. Because of low reimbursement rates, very few private dentists are willing to actively participate in the Medicaid program. Only 16% of North Carolina dentists actively participated[1] in Medicaid in 1998. Only six states had lower rates of dentists who actively participated in Medicaid (NCSL, 1998). The problem of the low participation rate is compounded by the simple fact that we do not have enough dentists and dental health professionals in North Carolina. North Carolina was ranked 47th in the number of dentists to population in 1997 (Morgan and Morgan, 1997).

Poor children are not adequately served and encounter particularly difficult access barriers. Thirty-six percent of all children entering kindergarten in this state (more than 31,000 children) have a history of dental disease. One out of every four children in this age group has untreated dental disease. Yet there are only 47 practicing pediatric dentists in the state. General dentists are trained to treat children in an outpatient setting, yet many are unwilling to treat very young children. Having expertise in pediatric dentistry is particularly important for the children with severe dental disease that require treatment under general anesthesia in a hospital.

Access to dental services is also difficult for older adults and people with disabilities who may be homebound or reside in institutions. A recent study of long-term care providers in 74 counties in North Carolina showed that about three-quarters of the facilities reported some difficulty in obtaining dental care for

[1] Active participation means that a dentist received more than $10,000/year in Medicaid payments.

their residents (Bell and Rieger, 2000). Approximately 40% of the reporting facilities described great or extreme difficulty in obtaining dental services. The problem was more acute for low-income residents who were covered by Medicaid to pay for dental care. More than 50% of the facilities reported great or extreme difficulty obtaining dental services for this population.
The NC Institute of Medicine's Task Force on Dental Care Access met over the course of four months and developed a set of 23 recommendations. Many of the recommendations have been implemented, either through acts of the 1999 NC General Assembly or by private or public initiatives (See Section ___). However, the Task Force's most important recommendation has not implemented:

Recommendation #1: Increase the Medicaid reimbursement rates for all dental codes 80% of Usual, Customary and Reasonable rates (UCR).

The Task Force recognized that the state would not be able to achieve its goal of improving access to dental services without the active involvement of private dentists. While the state has made significant headway in expanding the number of public health and non-profit dental clinics, such clinics are not sufficient to meet the needs of all in need. The active participation of more dentists in the Medicaid program is critical to improve access. However, dentists are reluctant to accept more Medicaid patients when the reimbursement rate is lower than their overhead. Medicaid's reimbursement rates only average about 62% of the UCR rates for some of the most common pediatric dental procedures, and 42% for other procedures (Perruzzi, 1999). Nationally, dentists spent more than 60% of their revenues on overhead costs (Children's Dental Health Project, 1998). Thus, many dentists lose money, or at best, can only cover their overhead costs when treating Medicaid patients.

The NC Institute of Medicine's Report on Dental Care Access contained two recommendations for further study:

- The NC•IOM, in conjunction with the NC State Board of Dental Examiners, the NC Dental Society, the Old North State Dental Society, NC Dental Hygiene Association, the NC Primary Health Care Association, the Dental Health Section and NC Office of Research, Demonstrations and Rural Health Development of the NC Department of Health and Human Services, should explore different methods to use dental hygienists to expand preventive dental services to underserved populations in federally funded community or migrant health centers, state-funded rural health clinics or not-for-profit clinics that serve predominantly Medicaid, low-income or uninsured populations.

- The NC•IOM, in conjunction with the NC Academy of Pediatric Dentistry, the UNC-CH School of Dentistry, the NC Area Health Education Centers (AHEC) program, and the Dental Public Health Program within the UNC-CH School of Public Health, should explore the feasibility of creating additional pediatric dental residency program(s) at East Carolina University, Carolinas Healthcare system, and/or Wake Forest University. A report should be given to the Governor and the Joint Legislative commission on Governmental Operations...The report should include the costs of establishing additional pediatric dental residency program(s) and possible sources of funding for pediatric dental residency programs, such as state appropriations or the Health Resources and Services Administration (HRSA), within the US Department of Health and Human Services.

The North Carolina General Assembly directed the NC Institute of Medicine to study these issues further and report back no later than May 1, 2000 (Sec. 11.14 of HB 168).

WORK GROUP REPORT ON: USING DENTAL HYGIENISTS TO EXPAND PREVENTIVE DENTAL HEALTH SERVICES TO UNDERSERVED POPULATIONS

The NCIOM pulled together a work group of key leaders from the NC State Board of Dental Examiners, NC Dental Society, Old North State Dental Society, NC Dental Hygiene Association, the NC Primary Health Care Association and the Dental Public Health Section (See Appendix A for a listing of participating work group members). The group met to discuss ways to more effectively use dental hygienists to expand preventive dental services to underserved populations (Recommendation #7 of the full Task Force Report on Dental Care Access).

Under current law, dental hygienists are only allowed to practice under direct supervision of a dentist (NCGS§ 90-233(a)). Direct supervision means that a dentist is physically present in the facility, but need not always be present in the room where services are rendered. There is one exception to this general rule. Dental hygienists that are employed by or under contract with county or state governmental dental health programs can perform oral health screenings, preventive and education services under the direction of a licensed public health dentist. Public health dentists need not be physically present at the time that such services are rendered.

At least thirty-three states permit dental hygienists to provide some services under the general direction of a dentist, although the settings and types of services they can provide varies by state (Silberman, 2000).[2] In some states, the services that can be provided without the direct on-site supervision of a

[2] Staff at the NC Institute of Medicine reviewed the dental statutes and regulations from 43 states and the District of Columbia.

dentist is limited to preliminary oral examinations, oral prophy, applying topical prophylactic agents or sealants. States sometimes also limit the location where services can be provided without direct supervision to institutions that serve underserved populations, such as schools, dental non-profit institutions, nursing homes or health care institutions.

The Work Group discussed different ways to expand the use of dental hygienists in North Carolina. In so doing, they recognized that dental hygienists would not be able to replace the role of dentists in providing comprehensive dental health services. *The recommendations that focus on expanding the role of dental hygienists do not replace nor minimize the importance of the Task Force's previous 23 recommendations aimed at increasing the number of private dentists willing to serve Medicaid patients, expanding the role of public health in providing preventive dental health services, increasing the recruitment effort of dentists and dental hygienists to serve underserved populations, and providing other educational and support services needed to remove barriers that low-income populations face in accessing dental services.*

Nonetheless, the Work Group recognized that better utilization of licensed hygienists could provide important educational and preventive services in federally-funded community and migrant health centers, state funded rural health clinics or not-for-profit clinics that serve predominantly Medicaid, low-income or uninsured populations. The Work Group made the following recommendations:

Work Group Recommendation A: The state should adequately fund Medicaid dental services and Dental Public Health to improve the quality of oral health for low-income or uninsured populations.

a) The panel reiterates that the most compelling factor toward resolving access to care issues is raising the reimbursement rate for Medicaid services to 80% UCR.

b) The panel also unanimously supports increasing funding for primary prevention and education services targeted to preschool aged children and their parents/caregivers, operated and administered by the Dental Health Section of the NC Department of Health and Human Services.

Work Group Recommendation B: The State should expand both clinical and primary preventive services to underserved populations short of changing the practice act. One way to do so would be to expand the use of dental professionals through the Dental Health Section of the NC Department of Health and Human Services. The Dental Health Section can provide adjunctive training for dental professionals (dentists, hygienists, assistants) in order to expand preventive and education services in a variety of settings (preschools, schools, non-profit clinics, nursing homes, etc.). The Dental Health Section can establish and administer state government dental health programs within dental facilities

whose mission is to serve low-income and Medicaid populations, on a case-by-case basis, to help improve the dental health among these populations. It was recognized by the work group that the Dental Health Section does not currently have the infrastructure (staffing or resources) to provide adjunctive training or evaluate the mission of dental facilities to ensure the focus on low-income and Medicaid populations. Funding from the state or other sources would be required. When fully implemented, the cost of such a process would be $300,000.

Work Group Recommendation C: The supply of dental manpower is inadequate to meet the needs of all the citizens of the state. Therefore, the General Assembly should appropriate:

a) $5 million through the community college system to expand existing dental hygiene, dental assistant and dental laboratory technician programs, and to start new accredited programs. The community college system should make expansion and establishment of these programs a top priority.

b) Adequate funding to the University of North Carolina School of Dentistry to expand their dental education programs for dentists, hygienists, and assistants to increase student enrollment in these programs.

WORK GROUP REPORT ON: EXPANDING PEDIATRIC DENTAL RESIDENCY PROGRAMS

Recommendation #14 of the full Task Force on Dental Care Access called for a special analysis of the prospects for additional pediatric dental care residency programs at locations other than the UNC-CH School of Dentistry. Subsequent to the publication of the final Task Force report, the North Carolina Institute of Medicine convened a workgroup whose objective was to explore the feasibility of additional residency positions at other locations throughout the state. Included in the discussions of this workgroup was a reconsideration of the possibility of increasing the number of pediatric dental residents at UNC-CH beyond the two-per-year recommended by the full Task Force. After extensive discussions of this matter, it was concluded that due to space and patient volume considerations, it would not be feasible to include more than two additional pediatric residents in the Chapel Hill program per year. Even then, additional financial support from the General Assembly would be needed to cover the stipends of these residents.

A second meeting of the workgroup has been planned for Monday, May 22, 2000 at which time representatives of the Carolinas Healthcare System in Charlotte, Wake Forest University in Winston-Salem, and East Carolina University in Greenville will join with representatives of the UNC-CH School of Dentistry in Chapel Hill, the UNC-CH School of Public Health, and the State Dental Health

Section of the NC Department of Health and Human Services to discuss the feasibility of new pediatric dental residency programs at any of these three sites (Charlotte, Winston-Salem, or Greenville). Preliminary indications are that there is a very good chance that a new residency program will begin within the next year at Wake Forest-Baptist Medical Center in Winston-Salem under the direction of Dr. Ray Garrison. The potential for additional residency positions at either ECU or Carolinas Healthcare System in Charlotte are less clear.

UPDATE ON NCIOM ORIGINAL RECOMMENDATIONS

The Task Force's original recommendations were grouped into the following five areas:

(a) increasing dentist participation in the Medicaid program;
(b) increasing the supply of dentists and dental hygienists in the state with a particular focus on recruiting dental professionals to practice in underserved areas and to treat underserved populations;
(c) increasing the number of pediatric dentists practicing in North Carolina and expanding the provision of preventive dental services to young children;
(d) training dental professionals to treat special needs patients and designing programs to expand access to dental services for these populations; and
(e) educating Medicaid recipients about the importance of ongoing dental care, and developing programs to remove non-financial barriers to the use of dental services.

Some progress has been made on many of these recommendations. The following is a list of recommendations from the 1999 report, along with a status report on the actions that have been taken, if any, to implement the recommendations.

Increasing dentist participation in the Medicaid program

- *Recommendation #1: Increase the Medicaid reimbursement rates for all dental procedure codes to 80% of UCR.*

  No action taken. This recommendation would require a new state appropriations of $6.0 in fiscal year 2001 (with a January 1, 2001 implementation date), and $11.9 annually thereafter to increase dental reimbursement rates to 80% of UCR.

- *Recommendation #2: The NC Dental Societies should develop an outreach campaign to encourage dentists in private practice to treat low-income patients.*

The NC Dental Society and Old North State Dental Society agreed to conduct an active outreach campaign to encourage more dentists to participate in the Medicaid program if the state increased its dental reimbursement rates. Even without the increase in reimbursement rates, the NC Dental Society has worked with the NC Division of Medical Assistance to begin an active outreach campaign to recruit dentists into the Medicaid program.

- *Recommendation #3: The Division of Medical Assistance should work with the NC Dental Society, the Old North State Dental Society, the NC Academy of Pediatric Dentistry, the Dental Health Section of the NC Department of Health and Human Services, the UNC-CH School of Dentistry, and other appropriate groups to establish a dental advisory committee to work with the Division of Medical Assistance on an ongoing basis. The Advisory Committee should also include Medicaid recipients or parents of Medicaid-eligible children.*

  The Division of Medical Assistance is in the process of working with the NC Dental Society to develop an advisory committee, which will include Medicaid patients and providers, as well as representatives of all elements of organized dentistry in the state.

Increasing the overall supply of dentists and dental hygienists in the state with a particular focus on efforts to recruit dental professionals to serve underserved areas and to treat underserved populations

- *Recommendation #4: Establish an Oral Health Resource Program within the Office of Research, Demonstrations and Rural Health Development to enhance ongoing efforts to expand the public health safety net for dental care to low-income populations in NC. The state cost of this program would be $1.0 million for each year for three years.*

  No action taken. This program would be charged with recruiting dental professionals to serve in dental underserved areas, and providing seed grants to communities to leverage private funds to establish or expand community-based facilities that provide dental care.

- *Recommendation #5: The NC Dental Society should seek private funding from the Kate B. Reynolds Charitable Trust, the Duke Endowment, and other sources to establish a NC Dental Care Foundation for the purpose of assuring access to needed preventive and primary dental care services in underserved communities and for underserved populations in our state.*

  The NC Dental Society is exploring this option.

- *Recommendation #6: Revise the NC Dental Practice Act to permit specially trained public health dental hygienists to perform oral health screenings as*

well as preventive and educational services outside the public school setting under the direction of a licensed public health dentist.

The North Carolina General Assembly, in their 1999 session, passed legislation to revise the NC Dental Practice Act to permit specially trained public health dental hygienists to perform oral health screenings as well as preventive and educational services outside the public school setting under the general direction of a licensed public health dentist (Sec. 11.65 of HB 168)

- *Recommendation #7: The NC•IOM, in conjunction with the NC State Board of Dental Examiners, the NC Dental Society, the Old North State Dental Society, NC Dental Hygiene Association, the NC Primary Health Care Association, the Dental Health Section and NC Office of Research, Demonstrations and Rural Health Development of the NC Department of Health and Human Services, should explore different methods to expand access to the services of dental hygienists practicing in federally funded community or migrant health centers, state-funded rural health clinics or not-for-profit clinics that serve predominantly Medicaid, low-income or uninsured populations. The study should include consideration of general supervision, limited access permits, additional training requirements, and other methods to expand preventive dental services to underserved populations.*

  See Section II of this report (above) for recommendations.

- *Recommendation #8: Existing and any future loan repayment programs established with the purpose of attracting dental professional personnel to work in rural or underserved areas should be accompanied by more stringent requirements to ensure that the dentists serve low-income and Medicaid patients.* Does not require legislation.

  The North Carolina Office of Research, Demonstrations and Rural Health Development (ORDRHD) has been able to recruit 15 additional dentists and 1 dental hygienist to practice in community facilities serving low income and uninsured patients. ORDRH has established more stringent requirements to ensure that the dental professionals that were recruited using loan repayment programs will serve low-income and Medicaid patients.

- *Recommendation #9: The Board of Governor's Scholarship Program and other state tuition assistance programs should carry a requirement of service in underserved areas upon graduation.*

  No action taken.

- *Recommendation #10: The General Assembly should direct the NC State Board of Dental Examiners to establish a licensure-by-credential procedure*

that would license out-of-state dentists and dental hygienists who have been practicing in a clinical setting in other states with the intent of increasing the number of qualified dental practitioners in the state.

This provision was enacted in Sec. 20.1 of HB 163. The NC State Board of Dental Examiners was directed to develop procedures for allowing North Carolina to license-by-credential out of state licensed dentists and dental hygienists. The Board was directed to report its recommendations for needed statutory changes to the General Assembly no later than May 15, 2000.

The NC State Board of Dental Examiners has developed proposed statutory language and proposed rules for licensure-by-credential and will be submitting the proposed statutory language to the 2000 General Assembly.

- *Recommendation #11: The NC State Board of Dental Examiners should be required to evaluate the competencies required by the different regional examinations to determine if these examinations ensure the same level of professional competence required to pass the North Carolina clinical examination. The NC State Board of Dental Examiners shall report its findings to the Governor and the Presiding Officers of the North Carolina General Assembly no later than March 15, 2001. If the Board concludes that participation in one or more regional examinations would not ensure minimum competencies, the Board shall describe why these other examinations do not meet North Carolina's standards and how the quality of care provided in North Carolina could be affected negatively by participating in such examinations. If the Board finds these exams to be comparable, procedures should be developed for accepting these examinations as a basis for North Carolina licensure in the year following this determination.*

  The NC State Board of Dental Examiners is gathering information about regional examinations and is planning to attend several exams during this year to observe their procedures and testing methods. Reports will be available following the visits.

- *Recommendation #12: The NC State Board of Dental Examiners should consider a change in the wording in the regulations governing Dental Assistants in order to increase access to dental services for underserved populations.*

  The NC State Board of Dental Examiners spent much of last year reviewing and revising its rules governing delegable functions for dental assistants and dental hygienists. New rules are to become effective August 1, 2000, with provisions for in-office training for dental assistants.

Increasing the number of pediatric dentists practicing in North Carolina and expanding the provision of preventive dental services to young children.

- *Recommendation #13: Increase the number of positions in the pediatric residency program at the UNC School of Dentistry from two-per-year to a total of four-per- year.*

  No action taken. This recommendation would require a new appropriations of $93,440 in the first year (to cover the costs of two pediatric residents and one dental assistant); $186,880 in the second year (to cover the costs of four pediatric residents and two dental assistants); and $252880 in the third year and thereafter (to cover the costs of six pediatric residents and two dental assistants).

- *Recommendation #14: The NC•IOM, in conjunction with the NC Academy of Pediatric Dentistry, the UNC-CH School of Dentistry, the NC AHEC program, and the Dental Public Health Program within the UNC-CH School of Public Health, should explore the feasibility of creating additional pediatric dental residency program(s) at ECU, Carolinas Healthcare System, and/or Wake Forest University. A report should be given to the Governor and the Joint Legislative Commission on Governmental Operations no later than March 15, 2000. The report should include the costs of establishing additional pediatric dental residency program(s) and possible sources of funding for pediatric dental residency programs, such as state appropriations or the Health Resources and Services Administration (HRSA), within the U.S. Department of Health and Human Services.*

  See Section III of this report (above) for Recommendations.

- *Recommendation #15: The Division of Medical Assistance is directed to add ADA procedure code 1203 to allow dentists to be reimbursed for the application of dental fluoride varnishes and other professionally applied topical fluorides without the administration of full oral prophylaxis.*

  The Division of Medical Assistance added this procedure code as of April 1, 1999.

- *Recommendation #16: Fund the Ten-Year Plan for the Prevention of Oral Disease in Preschool-Aged Children as proposed by the NC Dental Health Section. The goals of this effort would be to reduce tooth decay by 10% in all preschool children statewide in ten years; and reduce tooth decay by 20% in high-risk children statewide in ten years. The Ten-Year Plan would expand the use of public health dental hygienists from school-based settings to community-based settings such as day care centers, Smart Start programs, Head Start Centers and other community settings where high-risk children are*

located. The program would provide health education to mothers and caregivers, apply fluoride varnishes to young children, use dental sealants when appropriate, and provide continuing education courses for any professional who has contact with young children.

No action taken. This recommendation would require a new appropriations of $966,028 in the first year (to hire 10 public health dental hygienists, one field dentist supervisor, and four health educators), $1,827,673 in the second year (to hire and additional 10 public health hygienists, one field dentist supervisor and maintain staff hired in the first year, plus $165,000 for program evaluation), and $2,288,418 in the third year (to hire an additional 10 public health hygienists, maintain staff previously hired, plus $35,000 to complete the program evaluation).

- *Recommendation #17: The NC Dental Society, the NC Academy of Pediatric Dentistry, the Old North State Dental Society, the NC Pediatric Society and the NC Academy of Family Physicians should jointly review and promote practice guidelines for routine dental care and prevention of oral disease as well as guidelines for referring children for specific dental care, so as to provide all children with early identification and treatment of oral health problems and to ensure that their care givers are provided the information necessary to keep their children's teeth healthy.*

  No action taken.

- *Recommendation #18: The Division of Medical Assistance should develop a new service package and payment method to cover early caries screenings, education and the administration of fluoride varnishes provided by physicians and physician extenders to children between the ages of 9 and 36 months.*

  Provisions were put in place to allow pediatricians, nurse practitioners or physician's assistants to apply dental varnishes to the teeth of young children in order to more rapidly disseminate this proven preventive procedure among the state's low-income children. The Division of Medical Assistance began implementing this in the Carolina Access II and III project sites in the fall, 1999. They hope to implement this statewide by the spring 2000.

- *Recommendation #19: Support the enactment of HB 905 or SB 615 which would expand NC Health Choice to cover sealants, fluoride treatment, simple extractions, stainless steel crowns and pulpotomies.*

  NC Health Choice has been expanded to cover dental sealants, fluoride treatment, simple extractions, stainless steel crowns and pulpotomies. This provision was enacted as part of the 1999 Appropriations Act. (Sec. 11.9 of HB 168).

Training dental professionals to treat special needs patients and designing programs to expand access to dental services

- *Recommendation #20: The UNC-CH School of Dentistry, the NC AHEC system, and the NC Community Colleges that offer educational programs for dentists, dental hygienists and dental assistants should intensify and strengthen special-care education programs to train professionals on child management skills and how to provide quality oral health services to residents and patients in group homes, long term care facilities, home health, and hospice settings.*

  The UNC-CH School of Dentistry continues to offer predoctoral dental (DDS) students and dental hygiene students a variety of opportunities to develop knowledge and skills regarding child behavior management for dental care and dental care of people with disabilities. These opportunities include:

  Child behavior management for dental care:

  1. All dental students receive eight hours of classroom instruction on child behavior management. The DDS students obtain clinical experience by providing dental care for children in several settings in addition to the School of Dentistry including health departments and an Indian Health Service clinic. These sites offer students experience caring for children from a wide range of socioeconomic, ethnic and cultural backgrounds.

  2. All dental hygiene students receive two hours of classroom instruction on child behavior management. Students gain clinical experience by rotating through the Pediatric Dentistry Clinic. A special clinic elective is available for hygiene students who wish to gain additional pediatric dentistry training.

  Dental care for people with disabilities:

  1. All dental students receive eight hours of classroom instruction on providing dental care for people with disabilities. Approximately 75% of the dental students elect also to participate in a 21-hour clinical experience providing dental care for people with disabilities that live at a caregiver's home, group homes or supported apartments.

  2. All dental hygiene students receive 2 hours of classroom instruction on providing oral health care for people with disabilities. Hygiene students also have the option of taking a special elective where they provide preventive dental care for people with disabilities. This rotation includes visits to group homes where the students meet the residents and the staff works with them on improving their oral hygiene and health.

The Department of Pediatric Dentistry offers several AHEC courses focused on child behavior management and providing dental care for people with disabilities. These courses are provided several times per year throughout North Carolina. The Department of Dental Ecology also provides learning experiences in providing oral health care for children and people with disabilities.

- *Recommendation #21: Support the development of statewide comprehensive care programs designed to serve North Carolina's special care and difficult-to-serve populations.*

  Since the release of the NC Institute of Medicine's report on Dental Care Access in April, 1999, there have been a number of agencies that have established programs to provide dental services to institutional and other difficult-to-serve populations. However, additional work is needed to ensure that these programs are available statewide.

Educating Medicaid recipients about the importance of ongoing dental care, and develop programs to remove non-financial barriers to the use of dental services.

- *Recommendation #22: The Division of Medical Assistance, in conjunction with the NC Dental Health Section of the NC Department of Health and Human Services, should develop or modify community education materials to educate Medicaid recipients about the importance of ongoing dental care.*

  No action taken.

- *Recommendation #23: The NC Division of Medical Assistance should pilot test dental care coordination services to improve patient compliance and enhance the ability of low-income families and people with special health care needs to overcome non-financial barriers to dental care. The Division of Medical Assistance should evaluate the program to determine if care coordination increases utilization of dental care services. The evaluation should be reported to the Governor and the NC General Assembly no later than January 15, 2001.*

  The Division of Medical Assistance has health check coordinators in various counties that have tested dental care coordination to some degree. The Division is in the process of studying the results from these counties and plans to pilot test and extend dental care coordination to additional counties in the near future.

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APPENDIX A

Work Group on Dental Hygienists

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