

ORAL HEALTH Issue Brief


Policy Frameworks Supporting School-Based Dental Sealant Programs and Their Application in Minnesota

Despite strong evidence of the effectiveness of school-based dental sealant programs, most states are not taking full advantage of this significant opportunity to improve children's health.¹ The Minnesota Department of Health Oral Health Program, with financial support from the Health Resources and Services Administration (HRSA), sought an analysis of laws and policies in Minnesota and throughout the United States that either facilitate or impede school-based dental sealant programs. This Issue Brief identifies innovative laws and policies for more widespread consideration, adoption and implementation at the state level. It suggests that a statewide, coordinated school-based dental sealant program may provide a policy framework for evidence-based, effective, and sustainable school-based dental sealant programs. Finally, it examines the current state of the law in one state, Minnesota.

Background

Dental care is one of our nation's greatest unmet children's health needs, and tooth decay is the most common chronic disease affecting U.S. children.² Despite being almost entirely preventable,³ tooth decay is on the rise among young children and has been described as "a public health crisis."⁴ Without adequate preventive care and treatment, tooth decay can cause pain and infection and can lead to difficulties with eating, speaking, learning, and socializing, among other issues.⁵ Children with oral health problems are more likely to miss school and to perform poorly in school.⁶ National estimates suggest that oral disease causes children to miss approximately 51 million school hours a year,⁷ making it the number one reason for missed school.⁸

There are significant disparities in children's access to dental care, and low-income, minority, and rural children are particularly vulnerable. Children from lower-income households are twice as likely to suffer from untreated tooth decay as children from higher-income households.⁹ In 2014, more than 18 million low-income children went without dental care services or routine preventive exams.¹⁰ In 2012, the rate of tooth decay among Hispanic and African American children ages 2 to 8 was twice that of Caucasian children. Rural children are also less likely to have dental insurance and are more likely to seek care for preventable dental problems in emergency departments. In 2012, more than 200,000 U.S. children visited emergency rooms for dental conditions.¹¹



The American Dental Association and the American Academy of Pediatric Dentistry both endorse dental sealants as an effective means of preventing tooth decay.¹² Dental sealants are plastic coatings placed on the chewing surfaces of back teeth (also known as the “pits and fissures” of posterior teeth), which are the most cavity-prone areas. Approximately 90 percent of childhood tooth decay occurs in the chewing surfaces of the back teeth.¹³ Dental sealants are most effective when placed on children’s teeth soon after their teeth erupt.¹⁴ According to the Centers for Disease Control and Prevention, dental sealants can reduce tooth decay by over 80 percent in the two years after placement and can be effective for nearly five years.¹⁵


Dental sealant programs connected with schools have been characterized as an “optimal” way to reach children—especially children who may not otherwise have access to dental care.¹⁶ There are two types of dental sealant programs connected with schools. “School-based” dental sealant programs are conducted completely within the school setting.¹⁷ Dental providers who are not school employees use portable dental equipment or a fixed facility within the school to conduct the school sealant program. Some schools offer broader oral health programs that provide services such as screening, oral health education, fluoride varnish, prophylaxis (dental cleaning), or restorative services to replace missing or damaged teeth in addition to dental sealants. “School-linked” dental sealant programs collaborate with schools to deliver the sealants at a site other than the school such as in a clinic or dental office. Utilization per student is usually lower for school-linked programs than for school-based programs due to the need to travel to the non-school site.¹⁸ The primary focus of this Issue Brief is on “school-based” programs. .

The U.S. Community Preventive Services Task Force, an independent panel of public health experts appointed by the Centers for Disease Control and Prevention, strongly recommends school-based and school-linked dental sealant programs for preventing or reducing cavities on the posterior teeth of children. Economic studies have found that dental sealant programs are an efficient use of resources and that their benefits exceed their costs when sealant programs are used in high-risk populations.¹⁹ School-based dental sealant programs generally prioritize schools with high proportions of at-risk children who are less likely to receive dental care, such as children eligible for free and reduced-cost meal programs.²⁰

The purpose of this Issue Brief is to address legal barriers to school-based dental sealant programs and to highlight strategies to overcome these challenges. Particular attention will be paid to Minnesota’s laws and regulations relating to school-based dental sealant programs, but examples from other states will be highlighted throughout. Section 1 addresses common legal and practical issues that may arise when initiating a school-dental provider partnership. This section also shares best practices for forming a school-dental provider partnership. Section 2 turns to systemic policy barriers that can hinder school-based dental sealant programs, such as oral health workforce rules and reimbursement rules—with a particular focus on Medicaid policy. Section 2 also offers examples of how some states have overcome these challenges. Section 3 briefly describes the benefits of statewide coordination of school-based dental sealant programs. Finally, this Issue Brief examines the current policy framework for school-based dental sealant programs in Minnesota. While school-based dental sealant programs present a critical opportunity to improve children’s oral health, their potential has not been fully realized, and innovative laws and policies are needed to achieve that goal.

1. Considerations for Forming a School-Dental Provider Partnership

School-based dental sealant programs can be initiated at the state, county, community, or school level.²¹ Programs are often led by state department of health oral health programs, community health centers, school-based health centers, non-profits, private dental practices, small groups, or individuals (any of which are referred to generally as “program administrators” in this Issue Brief). The process for establishing a school-based dental sealant program may include forming a planning committee, conducting a needs assessment, and determining the target population for the program. The National Maternal and Child Oral Health Resource Center’s “Seal America” online manual contains practical tips for launching a school-based dental sealant program.²² This section highlights some of the legal issues that may need to be considered during this process.



Before initiating a school-based dental sealant program, dental sealant program administrators and the school or school district should consult with legal counsel to address any legal issues that may arise. They may wish to formalize the school-dental provider relationship in a Memorandum of Understanding. A Memorandum of Understanding (MOU) is an agreement between two or more parties and is often used to define the expectations and responsibilities of each of the parties.²³ Developing an MOU between the dental sealant program administrator and the school can help to ensure that the roles and responsibilities of each party are clearly set forth.²⁴ Formalizing an MOU can also help to ensure compliance with applicable federal and state laws.

A well-crafted MOU will likely address compliance with laws that protect the privacy of student health information, such as the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA). FERPA²⁵ is a federal law that protects the privacy of students' education records and gives parents certain rights with regard to these records.²⁶ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects health information and provides patients with certain rights to their health information, among other provisions.²⁷

The dental sealant program administrator and the school should consider reviewing the school's student health record policy closely with legal counsel to ensure compliance with all applicable requirements of FERPA and HIPAA. In addition, the parties should discuss with legal counsel the applicability of any state laws relating to health record privacy. A well-drafted MOU for a school-dental partnership should clearly establish the roles of the parties with respect to protecting student health information in compliance with these laws, and what information the partners may share with each other. There are several publicly available MOUs that may provide a starting point for individual programs to review and adapt to their state's legal requirements, such as the sample MOU from the West Virginia Public School System,²⁸ and the Smart Mouths, Smart Kids program in Colorado,²⁹ as well as a description of an MOU between the Washington DC Department of Health and its public schools.³⁰

Some dental sealant programs may rely on volunteers, whether in whole or in part, either for purposes of one-time events or as part of an ongoing program. According to a 50-state survey by the Policy Surveillance Program at Temple University, in January, 2015, thirty-one states had laws permitting dental hygienists to provide services on a volunteer basis.³¹

For programs that utilize volunteers, several legal factors will need to be considered to maximize volunteers' impact and to minimize potential legal risk and liability. For example, school sealant programs should ensure that all volunteer staff have adequate training on the school sealant program's assessment process for tooth decay, the sealant application technique, any relevant infection control protocols, and applicable privacy and confidentiality issues. In order to protect the safety of participating students, schools may need to establish security procedures for volunteers, including background checks, and ensuring compliance with school district policy. In addition, volunteer dental hygienists will want to confirm that their existing malpractice insurance policy covers incidents that could occur while they are volunteering with a school program.


Before initiating a school-based dental sealant program, the sealant program administrator and the school should consult with legal counsel to anticipate and address any other possible legal issues that may arise to ensure a successful and sustainable school-dental partnership.

2. Overcoming Policy Barriers

A. Scope of Practice for Dental Hygienists

Dental hygienists are typically the primary providers for school-based sealant programs.³² However, some states have restrictive rules that interfere with dental hygienists' ability to provide school-based sealant services.

Despite dental hygiene education accreditation standards which prescribe consistent training requirements for dental hygienists nationwide, state scope of practice policies for dental hygienists vary widely.³³ Scope of practice rules establish the procedures that hygienists can perform, the level of supervision required, and the locations in which dental hygienists



can provide services. State laws and state regulatory boards determine dental hygienists' scope of practice. Most preventive dental services fall within dental hygienists' authorized scope of practice in most states, including the application of fluoride and the placement of sealants. However, some state laws have stringent supervision requirements that mandate that hygienists work directly with dentists to provide these services.

Supervision requirements for dental hygienists are generally categorized into three levels: 1) *direct access*, 2) *direct supervision*, and 3) *general supervision*.³⁴ *Direct access* generally means that dental hygienists have less supervision and more autonomy. Dental hygienists operating under *direct access* are permitted to initiate treatment without the authorization of a dentist and can provide services without the presence of a dentist. In contrast, dental hygienists operating under *direct supervision* requirements have more limited autonomy and must have a dentist physically present in order to provide services. Finally, dental hygienists operating under *general supervision* must receive authorization from a dentist to perform services for specific patients, but the dentist is not required to be physically present at the time the hygienist renders the treatment.

Prior Exam Rules

Some states with general supervision rules may also require an examination by a dentist before the hygienist is allowed to provide services. These rules are known as “prior exam” rules. In the school-based sealant context, some states’ “prior exam” rules require a dentist to examine a child before the dental hygienist can place a sealant. The majority of states have eliminated these “prior exam” rules in recent years. However, according to a recent 50-state survey by the Oral Health Workforce Research Center, thirteen states still required children to be examined by a dentist before a dental hygienist can apply sealants.³⁵ These rules make these programs more cumbersome and expensive.³⁶

In general, those opposed to allowing more autonomy and expanded scope of practice for dental hygienists have raised concerns about protecting patient safety and preserving quality of care. Proponents of expanding scope of practice for dental hygienists have argued that allowing more autonomy for dental hygienists can help to increase access to care for underserved populations who would otherwise not have access to oral health services. Any expansion of scope of practice must balance potential benefits with protecting patient safety. A 2016 study found that in states that reduced the direct supervision requirements for dental hygienists, there was a statistically significant improvement in overall oral health outcomes.³⁷


Some states that have eliminated these prior exam rules have already seen improved oral health outcomes for low-income children. For example, in 2000, the South Carolina legislature removed the requirement that a patient see a dentist before a dental hygienist could initiate any preventive services for a patient in a public health setting. Five years after the state adopted this rule change, state data demonstrated that “sealant use increased, the incidence of untreated cavities decreased, and treatment urgency rates declined among Medicaid-insured children.”³⁸

A number of organizations have recommended reducing such dental hygienist supervision requirements to expand children's oral health access. The U.S. Community Preventive Services Task Force found that sealant placement was more cost-effective “when dental hygienists, rather than dentists, were used to determine whether sealants were appropriate for individual students.”³⁹ The Centers for Medicare and Medicaid Services recommends that states improve children's oral health access by reducing supervision requirements for dental hygienists who work in schools and other community-based settings.⁴⁰ The National Governor's Association also recommends that states “consider doing more to allow dental hygienists to fulfill these needs by freeing them to practice to the full extent of their education and training.”⁴¹

B. Reimbursement

Expanding Medicaid Reimbursement for Dental Hygienists

Medicaid reimbursement can be an important funding stream for school-based sealant programs. However, many oral health professionals participating in these programs face regulatory hurdles in obtaining reimbursement for services



provided in this setting. In fact, reimbursement challenges have been identified as one of the biggest obstacles hindering school-based sealant programs.⁴²

In January 2016, the Children’s Dental Health Project convened a national Sealant Work Group (SWG) to suggest strategies for improving the sustainability and operations of school-based dental sealant programs.⁴³ The SWG consisted of thirteen individuals with considerable experience managing, researching or implementing school-based sealant programs. The SWG identified Medicaid regulatory hurdles as one of the top policy priority areas.⁴⁴ Among other recommendations, the SWG recommended that state Medicaid programs allow all licensed dental providers (including dental hygienists and dental therapists) to enroll as Medicaid providers and to allow them to receive direct reimbursement for oral health services provided in all settings.⁴⁵

In 2016, the Oral Health Workforce Research Center found that only 18 states allow dental hygienists to enroll as Medicaid providers and receive reimbursement directly from Medicaid.⁴⁶ Some states have been reluctant to add dental hygienists as Medicaid providers due to concerns about growing Medicaid costs. However, the cost of early interventions to prevent tooth decay is much less expensive than the cost of major clinical interventions (such as fillings, root canals, etc.) if tooth decay progresses. Multiple economic studies that analyzed Medicaid claims have found that school-based sealant programs resulted in overall cost-savings when delivered in settings where the children were at high risk for dental caries.⁴⁷ Moreover, sealant placement is more cost-effective when dental hygienists, as opposed to dentists, are utilized to determine whether sealant placement is appropriate.⁴⁸

Some states have taken action to remove Medicaid reimbursement restrictions that prevent dental hygienists from enrolling as providers. For example, in 2016, the Department of Vermont Health Access received approval from the Centers for Medicare and Medicaid Services (CMS) for a State Plan Amendment to add licensed dental hygienists who practice in public health settings as Medicaid providers so that they can bill Medicaid directly.⁴⁹ Participating dental hygienists are required to have a collaborative practice agreement with a Vermont licensed dentist.

Wisconsin began to allow dental hygienists to be certified as Medicaid providers and bill directly for services provided in school settings, public health departments, and dental and dental hygienist schools in 2006.⁵⁰ Within two years of Wisconsin allowing dental hygienists to enroll as Medicaid providers and bill for sealants directly, school sealant programs grew tenfold.⁵¹


In August 2017, Wisconsin passed a law that went even further—allowing dental hygienists to work without the supervision of dentist and to bill Medicaid directly for services provided in additional outpatient medical settings, including community health centers.⁵² This bill received broad, bipartisan support and was backed by a number of organizations, including the Wisconsin Hospital Association, Children’s Health Alliance of Wisconsin, Children’s Hospital of Wisconsin, Wisconsin Dental Association, Wisconsin Public Health Association, Wisconsin Oral Health Coalition and American Academy of Pediatrics-Wisconsin Chapter. The impact of this new law is just beginning to be seen, but community health centers have already stated that they plan to hire dental hygienists as quickly as possible to provide needed dental care to underserved children and adults.⁵³

Community health centers are community-based organizations that serve vulnerable populations with limited access to health care. They serve as an important safety net and provide health care services regardless of a patient’s insurance status or ability to pay. Most community health centers receive federal grant funding, but Medicaid reimbursement is also an important source of revenue for community health centers. Some community health centers also operate dental sealant programs in schools, and can be an important source of oral health care for underserved children.⁵⁴

States seeking to expand school-based sealant programs may consider changes to state Medicaid policies to improve the financial sustainability of these programs and redirect scarce dollars to proven, cost-effective preventive care.

Streamlining Medicaid Managed Care Organization Enrollment and Contracting Processes

Dental hygienists operating in school-based dental sealant programs may also encounter challenges in receiving reimbursement from Medicaid Managed Care Organizations (MCOs). More than half of Medicaid beneficiaries receive



their care from MCOs that contract with state Medicaid programs to deliver services to enrollees.⁵⁵ Thirty-nine states currently contract with MCOs, and all but one of those states contract with multiple MCOs.⁵⁶ For example, the state of Minnesota currently has contracts with 8 MCOs. New York currently utilizes the most MCOs of any state and has a total of 23 contracts with MCOs operating in the state. Across the United States, states currently have over 275 contracts with MCOs. When a state utilizes multiple MCOs for oral health services, dental hygienists need to be enrolled with each MCO from whom they wish to be reimbursed.⁵⁷ Enrollment, sometimes also referred to as “credentialing,” is the process through which MCOs ensure that participating providers meet professional, certification, and licensure requirements under applicable state and federal laws.⁵⁸ MCOs can also change frequently, which means that school-based sealant programs and their practitioners must reapply for enrollment on an ongoing basis. This cumbersome enrollment process can serve to hinder school-based dental sealant programs.

The Sealant Work Group and the American Dental Association have advocated for states to create a streamlined enrollment process to address these administrative hurdles. The American Dental Association recommends the use of a state-supported common enrollment process for use across all MCO contractors.⁵⁹ Several states—such as Maryland, New Jersey, and Oklahoma—have recently taken steps to streamline enrollment processes. For example, Maryland contracted with an administrative services organization (ASO) to simplify its Medicaid credentialing process and to expedite payment of claims.⁶⁰ In 2018, the Department of Healthcare and Family Services in Illinois began to transition to an online provider enrollment program in order to simplify credentialing and lower administrative costs to providers.⁶¹

Other challenges regarding MCOs remain. Some states, including Minnesota, permit MCO’s to subcontract the administration of dental services to a third party, with whom the state agency does not have a direct contractual relationship. Even in states whose Medicaid agencies allow dental hygienists to bill directly for services, some MCOs have reportedly rejected those submissions and required dentists to submit the claims instead.⁶² The Sealant Work Group recommends that state Medicaid programs require that MCOs abide by the same payment and contracting requirements that govern the state Medicaid program—and enforce that requirement.

Medicaid “Free Care Policy” Reversal

For many years, a federal policy known as the “Free Care Policy” prohibited providers from billing Medicaid for services if those same services were offered free of charge to the community.⁶³ For example, if a school-based sealant program provided free oral health services to all students, the program could not bill Medicaid for the oral health services it provided to Medicaid-enrolled children. This served to hinder some states from establishing school-based sealant programs. In 2014, CMS announced a reversal of this policy by stating that Medicaid would pay for services provided to Medicaid-enrolled children even if other children were not billed.⁶⁴ This effectively removed one significant barrier to the establishment of school-based sealant programs and opens up new opportunities for reimbursement and increased sustainability of these programs.⁶⁵

Medicaid Reimbursement Rates

When Medicaid dental services are provided on a fee for service basis, the reimbursement rate may be compared to commercial dental charges. If the Medicaid reimbursement rate is substantially lower than commercial dental charges, few private dentists find it financially feasible to accept patients covered by Medicaid, which creates a barrier to access to care, including through school-based dental sealant programs.

Reimbursement from Medicaid and other payers can be a crucial funding stream for school-based dental sealant programs. Policy change relating to reimbursement at the state level can help expand school-based dental sealant programs and support their long-term sustainability.



C. Other Legal Issues

This Issue Brief is not an exhaustive analysis of the legal issues involved in school-based dental sealant programs, but rather a starting point for programs to consider. There are additional legal issues that school sealant program administrators and schools should discuss with their legal counsel prior to implementing a school-based dental sealant program. For example, a school-dental partnership should work with legal counsel to determine what type of parental consent is needed for the provision of dental sealants in the school setting. The Colorado Department of Public Health and Environment's Oral Health Program has one example of a parental consent form.⁶⁶ In addition, one of the most difficult aspects of the consent process is getting the forms returned by parents.⁶⁷ The school can greatly assist in the process by emphasizing the importance of getting these forms returned at various parent-teacher events.

3. Statewide Coordination

Statewide coordination of school-based sealant programs offers a number of benefits. It provides infrastructure and a forum for sharing information, including evidence-based practices, as well as facilitating data collection and data analysis. Statewide coordination may facilitate interventions to reduce disparities in access to preventive services such as dental sealants. Finally, statewide coordination of school sealant programs can assist in early identification of barriers and opportunities in state law and policy, and facilitate their resolution through collective impact, rather than individual school-based dental sealant programs perceiving challenges as isolated and seeking individual solutions.

The Association of State and Territorial Dental Directors collects best practice approach reports on school-based dental sealant programs, which provide an overview of evidence-based practices in the context of contemporary real-world implementation.⁶⁸ For example, the Oregon Health Authority operates a statewide dental sealant program, as required under a 2015 state law.⁶⁹

Application of the Policy Framework in Minnesota

Having examined policy frameworks to support school-based dental sealant programs, this Issue Brief now turns to the application of this policy lens to one state, Minnesota.


Considerations for Forming a School-Dental Provider Partnership

Minnesota's 2013 School-Based Dental Sealant Program Manual includes a sample MOU in an appendix.⁷⁰ The sample MOU should be reviewed prior to use in order to ensure compliance with changes to the relevant law in the intervening years, including 2017 changes to Minnesota's law authorizing collaborative practice by dental hygienists. Minnesota's law governing collaborative practice dental hygiene will be addressed in a forthcoming Issue Brief.

Dental hygienists who are licensed in Minnesota may provide services on a volunteer basis, as long as all applicable requirements (including supervision by or a collaborative agreement with a licensed dentist) are met. Minnesota law also provides for a guest license which authorizes dental hygienists licensed in other states to provide services on a volunteer basis under certain conditions.⁷¹

Scope of Practice for Dental Hygienists

Dental sealants may be applied by dental hygienists in Minnesota under general supervision.⁷² Dental hygienists may also apply sealants without a dentist being present if they enter into a collaborative practice agreement with a dentist.⁷³ Minnesota law on collaborative practice authorizes dental hygienists, who enter into a written agreement with a dentist,



to provide dental sealant services in schools.⁷⁴ Dental hygienists with a collaborative practice agreement can perform an assessment for tooth decay and place dental sealants on children in schools without a dentist's prior exam.

The Minnesota Department of Health anticipates that 2017 changes to the statute governing collaborative practice will enable more dental hygienists in the state to take advantage of this option to participate in school-based dental sealant programs.

Reimbursement

In Minnesota, Medicaid reimbursement is available for covered services provided by dental therapists and advanced dental therapists.⁷⁵ In general, services provided by dental hygienists are not eligible for Medicaid reimbursement directly to the dental hygienist. However, collaborative practice dental hygienists who provide dental services may be included in a provider file as a rendering provider, with their health care facility, program, or nonprofit organization listed as the pay-to provider.⁷⁶ Application of sealants once every five years on permanent molars is included among the medically necessary dental services for children for which Medicaid coverage is available in Minnesota.⁷⁷ In general, application of sealants on primary teeth and on permanent premolars is not currently eligible for Medicaid reimbursement in Minnesota.

In 2017, the federal Centers for Medicare and Medicaid Services (CMS), cited "indications both that Minnesota children enrolled in Medicaid do not currently have sufficient access to dental services and that not enough dental providers participate in Minnesota Medicaid to ensure access to dental care for the state's child enrollees."⁷⁸ CMS noted that in federal fiscal year 2015, the national average of Medicaid-enrolled children who received a preventive dental service was 46 percent, while in Minnesota, where reimbursement rates were the lowest in the nation, only 37 percent of Medicaid-enrolled children received a preventive dental service. In response to the CMS letter, the Minnesota legislature raised reimbursement rates for dental services for Medicaid-enrolled patients. Reimbursement rates for dental services from some Minnesota providers were raised 23.8 percent for medical assistance members under age 21 in July 2017, and rates were raised 54 percent for dental services for MinnesotaCare members in January 2018.⁷⁹ The Minnesota Association of Community Health Centers provides services to community health centers in the state.

Statewide Coordination

A bill introduced in 2018 in the Minnesota legislature, H.F. 4194, would have required the state commissioner of health to develop a statewide, coordinated school dental sealant program, but it did not garner passage.⁸⁰ Relying on its broad public health authority, the Minnesota Department of Health launched the SEAL Minnesota initiative to foster a statewide, coordinated school sealant program network.⁸¹ As it unfolds in the coming years, SEAL Minnesota is likely to evolve in order to provide evidence-based support to expanded school-based dental sealant programs.

Conclusion

School-based dental sealant programs present a critical opportunity to improve children's oral health, particularly among vulnerable children who are less likely to receive dental care in other settings. Despite the strong evidence of the effectiveness of school-based dental sealant programs, their potential has not been fully realized in many states. However, states have enormous potential to expand dental sealant programs and improve their sustainability by eliminating restrictive requirements that hinder school-based dental sealant programs, such as prior exam rules and restrictive Medicaid payment policies. States can facilitate school-based dental sealant programs through statewide coordination as well. Sustainable legal and policy frameworks play a key role in promoting the success of school-based dental sealant programs and in improving children's health outcomes.



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