Approved: March 16, 2000
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on March 8, 2000 in Room 423-S of the Capitol.

All members were present except: Representative Brenda Landwehr, Excused

Committee staff present: Emalene Correll, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Joyce Volmut, Kansas Association of Medically Underserved
Kevin Robertson, Kansas Dental Association
Dr. Kelly Douglass
Vickie Armstrong, Kansas State Nurses Association
Judy Eyerly, Douglas County Dental Clinic
Susette Schwartz, CEO, Hunter Health Clinic
Cathy Harding, Executive Director Flint Hills Community Health Center
Barbara Stevko, M. D., Health Officer, Shawnee County Health Agency

Others attending: See Attached Sheet

The Chairperson announced that Mr. Merle Raber and Via Christy Family Residency from Wichita were in the audience.

The Chairperson opened the hearing on **HB 2990 - Relating to the dental practices act.**

Staff gave a briefing on **HB 2990** stating had seen the concept earlier and it originally came from the SRS Oversight Committee after the Committee worked this summer on dental services for Medicaid and Chip populations and discovered shortages of dental services. The statute that is amended is a statute that creates an exception to the Kansas Dental Practice Act. That Act forbids or prohibits dentists from being employed by other persons and this creates an exception to allow certain types of facilities that provide generally charity care services or services to the underserved to employ dentists. There seems to be some misunderstanding about who all is included in the places where dentists may be employed. This only deals with a not-for-profit hospital.

Joyce Volmut, Executive Director, Kansas Association for the Medically Underserved, testified in support of **HB 2990**, that allows FQHC's to fulfill their federal mandate. It is believed this is a step in the right direction toward providing access to dental care but not enough. There are currently three FQHC's that have dental clinics. Two are located in Wichita and one in Emporia that is a health department. There are six more clinics involved in some level of investigation regarding the need for dental care. A balloon which is attached to testimony is needed to strengthen this bill (See Attachment #1).

The Chairperson stated it was his understanding after the last meeting on the dental practices act that Ms Volmut was going to work with the Dental Board and crunch these differences out before a bill was drafted. This is different from what the Oversight Committee recommended.

Ms. Volmut stated the Dental Board had not seen the testimony, not everything was worked out. We came to some agreement on some of the differences.

The Chairperson asked, your request is different from what the Oversight Committee suggested?

Ms. Volmut replied, yes.

The Chairperson asked, so your request has nothing to do with what was worked in the Oversight Committee?

Ms. Volmut stated she testified in the Oversight Committee and some of the recommendations that were made were based upon the testimony given. The information today is pretty much similar to that testimony. There is a difference of opinion in what the Oversight Committee requested because had talked out removing the insurance and there was a lot of support for that and there are members on this committee that are also on that committee.

The Chairperson stated we were not here to settle turf battles but would grant a little leeway to try to work through this bill.

Kevin J. Robertson, Executive Director, Kansas Dental Association, testified as a proponent to **HB 2990,** asking the Committee to consider an amendment to require FQHCs to report to the Health Care Reform Legislative Oversight Committee detailing the income levels and insurance status of their patients an annual basis. This proposed amendment is on line 27 to add, "except that a federally qualified health center shall be required to provide a report to the Health Oversight Committee indicating the income level of their patients, and the percentage of patients covered by dental insurance in the preceding year." It is not intended to create burdensome requirement for the FQHCs as it is our understanding the Kansas Association of Medically Underserved already compiles such information. Since **HB2990** exempts FQHCs from the law, the reporting would provide the legislature with some oversight of their activities.

Kevin Robertson stated they would probably accept the amendment by Ms. Volmut to insert "or National Health Services Corps site" and strike only "medical and hospital care" on line 33 and insert only "Health Wave" on line 35, but would have to consult with the Executive Committee (See Attachment #2).

Dr. Kelly D. Douglass, a periodontist practicing in Topeka and President of the Kansas Dental Board, testified in support of **HB 2990**. The Dental Board acknowledges the need for the proposed legislative changes in **HB 2990**, and maintain the language presented in the current form of this bill, which ensures access to safe care for the population to be determined by dentists and not nonprofessional corporations other than the exception of federally qualified health centers, and maintain the regulatory function of the Dental Board over this care and those providing it (See Attachment #3).

Vickie Armstrong, R. N., Kansas State Nurses Association, supported **HB 2990** with the amendments by Ms. Volmut, stating healthy teeth is important as it makes a person feel good about themselves, gives fresh breath and a nice smile. Poor dental care can lead to major health problems in adulthood. Registered nurses as front line caregivers see children and adults whose dental care is so inadequate that it interferes with their self concept (particularly in children); health in general, because of chronic pain or malnutrition or a combination of both of these (See Attachment #4).

Judy Eyerly, Douglas County Dental Clinic, testified as a proponent to **HB 2990**, with the amendments by Ms. Volmut. According to a state analysis, approximately 37% of the county has difficulty accessing dental care by one of the above methods. The analysis done by the state lead the federal government to declare that Douglas County is a Dental Health Professional Shortage Area.

Ms. Eyerly's main area of concern was the restrictive language that remains in the bill. The language effectively kills any change Douglas County has of creating a viable dental clinic in Lawrence. We ask that 200% below the poverty restriction be stricken and consider a sunset provision to evaluate it to see what sort of impact it has. (See Attachment #5).

Susette Schwartz, CEO, Hunter Health Clinic, Wichita, testified in support of **HB 2990**, with the amendments by Ms. Volmut. The Hunter Health Clinic receives federal funding to provide primary health care services to all people, regardless of ability to pay. As amended, the bill would allow Hunter

Health Clinic to employ or contract with a licensed dentist to provide dental services because Hunter is a federally qualified health center (FQHC) (See Attachment #6).

Cathy Harding, Executive Director, Flint Hills Community Health Center, Emporia, Kansas, testified as a proponent to **HB 2990**, stating their dental clinic opened one month ago. The decision to commit to this clinic was the result of years of public and professional concern, community needs assessments, and the determination by the federal government that Emporia is a designated dentally underserved area. No dentist in Emporia, or Lyon County, accepts new Medicaid patients. Low-income, uninsured people in the area had no options for many years (See Attachment #7).

Barbara Stevko, M.D., M.P.H., Health Officer, Shawnee County Health Agency, testified in support of **HB 2990** with amendments, stating there is an enormous need for dental care for the indigent and working poor in Kansas. The county was designated a Dental Professional Shortage Area for indigent services in September 1996, by the Department of Health and Human Services. This was based on a low-income population at or below 200% of poverty of 35,624, who were served by 2.4 FTE dentists, a ratio of 14,843:1. For the individual living on the margins of poverty, dental health impacts general health and employability. The existing legislation places an unnecessary burden on organizations who attempt to help the indigent and others who can not afford dental care in the first place. The existing legislation denies or limits funding from grants that could help establish needed dental programs and help maintain them (See Attachment #8)

The Chairperson stated that time had run out, would not close the hearing, but would try to continue at a later date.

The meeting adjourned at 3:10 p.m. and the next meeting will be March 13.

HEALTH AND HUMAN SERVICES

DATE March 8, 2000

NAME	REPRESENTING
Susette Schwartz	Hunter Health Clinic Wichita
Judy Eyerly	Douglas Co. Dental Clinic
Joyce Volmut	Kans. Assoc Med. Underserved
Suzanne Gierch	" " " "
Jeri Freed	Kansas Dental Board
Barbara J Gibson	KDHE
Kevin Robertson	KS Dental Assn
Kelly D Douglass DDS, MS	KS Dental Board
Emily Rico	HAMU
Daryl Putschman	Kansas Assoc/Medically Underserved
Vicki Armstrong	Kansas State Nurses Assoc.
[illegible]	[illegible]
Nina Aterieu	John Bottenberg for Delta Dental
Cathy Harding	Flint Hills Community Health Center
Kevin Barone	Hein/Weir chtd

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

112 SW 6th Ave., Suite 201 Topeka, KS 66603 785-233-8483 Fax 785-233-8403 www.ink.org/public/kamu

March 8, 2000

HB 2990
Health and Human Services Committee
Representative Gary Boston Chair

My name is Joyce Volmut, I am the Executive Director of the Kansas Association for the Medically Underserved. Once again we're faced with making a decision about access to dental care for those individuals who do not have access to dental care.

I am here today in support of HB 2990 that allows FQHC's to fulfill their federal mandate. We believe this is a step in the right direction toward providing access to dental care but not enough. Currently three FQHC's have a dental clinic. Two of these are located in Wichita and one in Emporia. Six more clinics are involved in some level of investigation regarding the need for dental care in their area., in Salina, Overland Park, Kansas City KS, Garden City, Lawrence and Topeka. Not all of these will be in FQHC, however many of these may be National Health Service Corps sites. We believe it necessary to strengthen this bill and are therefore providing the following amendments. A balloon on the attached page create a stronger bill and can serve many of the clients in critical need who must now be turned away because of the discriminatory barriers created by the dental practice act itself.

These amendments include the following:

- Line 23 following indigent persons, insert or other person with limited access to dental care.
- Line 25, following federally qualified health center, insert the words National Health Service Corps site.
- Line 32, place a period after the word services. And strike the remainder of that sentence "~~and are not indemnified against cost arising from medical and hospital care or dental care by a policy of accident and sickness or an employee health benefits plan.~~"
- Line 35, insert Health Wave, Medicare and other publicly funded health care programs.

Rationale:

1. Although the majority of individuals served meet the definition of dentally indigent as outlined in the Dental Practice act, there are those in need of service who do not. Most cannot because of access issues.
   - They cannot meet current insurance deductibles.
   - They have other catastrophic illnesses.
   - They are unable to access care in the private sector for other reasons.

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- They are long standing users of primary care clinics or FQHC's.
- They have incomes that fluctuate around 200% of the federal poverty level.
- They require a great deal of support, including case management and other support services, in order to be compliant with care.
- They have only recently begun to have higher incomes or just entered the job market and struggle to rise above the poverty level.
- They have a right to choose the provider of choice.

2. Insertion of National Health Service Corps -
For the past ten years we have worked closely with the National Health Service Corps to improve access to care across the state. Through this resource we have been able to get dentists, nurse practitioners, physicians, physician assistants and mental health providers as loan repayment recipients or to fulfill their obligation for NHSC scholarships that allowed them to continue their education. Today there are 5 dentists now practicing in the state, 2 more have been matched- 4 are in private practice in western Kansas, 1 at the Flint Hills 1 has already been matched with the Marion Clinic (Martin de Porres dental clinic) in Topeka and the clinic is on a waiting list for a second.

National Health Service Corps dentists are eligible to practice in any of the dentally underserved of the state, however like the FQHC's they must see clients in need within their catchment area, regardless of ability to pay; they must charge based on a sliding fee scale and they must agree to see Medicaid, Medicare, Health Wave and other publicly funded programs. A copy of loan repayment and scholarship requirements, maps of health professional shortage areas, including dental and a list of provider placement in each of the specialty areas across the state are attached to this testimony.

3. Dentally Indigent Definition -
We believe the language in the dental practice act that defines the dentally indigent is discriminatory in nature and serves as a barrier to care. HB 2586 removed these barriers. HB 2990 does not. The barriers created are two:

A. The definition forbids clinics from providing dental care to anyone with insurance - even when that insurance does not provide dental coverage and even when the persons income is below 200% of poverty.
For example, if a person is on a fixed income but has health insurance, regardless of the coverage, they must now be turned away by the clinic. A second example would be an individual at or below 150% of poverty but happens to have dental insurance and cannot afford their co-payment. This person must also be turned away by the clinic. *There are countless cases such as these and consequently these persons go untreated and unseen by anyone.* Most often these are elderly persons with Medicare and supplemental insurance. We believe this is not acceptable.
B. The definition restricts clinic revenue to only self pay and available grant dollars. Yet for non-FQHC sites few grant dollars exist. Yet there are communities, who are working to improve dental access for the underserved -

even without the possibility of new grant dollars. Such is the case with the Douglas County Dental Clinic, of which you will hear testimony, or Good Samaritan Clinic in Wichita or the Salina Cares Clinic. In these instances a mix of revenue is necessary in order for them to remain viable.

4. The law is unclear about whether other publicly funded insurance or payers are covered, such as Medicare, Health Wave, the Ryan White AIDS program, the Migrant Health Voucher program. We believe this must be clarified.

It's our understanding after talking with Kevin Robertson, Executive Director of the Kansas Dental Association, that these are recommendations the dental association can generally support.

In closing, the goal of the dental clinics, whether they be in FQHC's or what's commonly referred to as dentally indigent clinics is to increase access to quality dental care. This these sites must be able to provide preventive services and not just be pain abatement centers. They must be able to establish a relationship with the client. We believe this is an important part of changing client behaviors and improving overall health of the patient. We have already demonstrated this in medical care. When people receive the care they need, they stay at work and can be generally more productive. We believe the same- perhaps to an even greater extent exists where dental health is concerned, especially because the effects of good and early treatment are visual. A person looks and feels better and because scientific evidence now shows a greater correlation with poor dental health and the onset of chronic illness, such as health disease and diabetes.

We urge you to strongly consider favorable passage of HB 2990 with our proposed amendments. Thank you for this opportunity to speak with you about the dental needs of the clients we serve.

HOUSE BILL No. 2990

By Committee on Appropriations

2-16

AN ACT relating to the dental practices act; amending K.S.A. 1999 Supp. 65-1466 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1999 Supp. 65-1466 is hereby amended to read as follows: 65-1466. (a) (1) Notwithstanding any other provision of the dental practices act, a not-for-profit corporation having the status of an organization under 26 United States Code Annotated 501(c)(3) which is also a facility qualified under subsection (b) of K.S.A. 65-431 and amendments thereto to select and employ professional personnel, an indigent health care clinic as defined by the rules and regulations of the secretary of health and environment, ~~a federally qualified health center~~, or a local health department may employ or otherwise contract with a person licensed under the dental practices act to provide dental services to dentally indigent persons.

(2) Notwithstanding any other provision of the dental practices act, a federally qualified health center may employ or otherwise contract with a person licensed under the dental practices act to provide services to any person.

(b) Dentally indigent persons are those persons who are: (1) Determined to be a member of a family unit earning at or below 200% of poverty income guidelines based on the annual update of ``poverty income guidelines" published in the federal register by the United States department of health and human services, and are not indemnified against costs arising from medical and hospital care or dental care by a policy of accident and sickness insurance or an employee health benefits plan; or (2) eligible for medicaid; or (3) qualified for Indian health services. This subsection shall not be construed to prohibit an entity under subsection (a) which enters into an arrangement with a licensee under the dental practices act for purposes of providing services to dentally indigent persons pursuant to subsection (a) from defining ``dentally indigent persons" more restrictively than such term is defined under this subsection.

(c) A licensee under the dental practices act who enters into an arrangement with an entity under subsection (a) to provide dental services pursuant to subsection (a): (1) Shall not be subject to having the licensee's

insert "or other persons with limited access to dental care".

Insert "or National Health Service Corps site"

Strike lines 32,33,34 (~~and are not indemnified against cost arising from medical and hospital care or dental care by a policy of accident and sickness or an employee health benefits plan.~~

Insert " Health Wave, Medicare and other publicly funded health care programs".

license certificate suspended or revoked by the board solely as a result of such arrangement; and (2) may not permit another person who is not licensed in Kansas as a dentist, and is not otherwise competent, to engage in the clinical practice of dentistry. No entity under subsection (a) or any other person may direct or interfere or attempt to direct or interfere with a licensed dentist's professional judgment and competent practice of dentistry.

(d) A dentist who is classified as ``retired'' by the Kansas dental board is not required to pay the annual renewal fee or comply with the dental continuing education requirements if the dentist elects to provide dental services to the indigent through one of the entities specified in subsection (a). A ``retired'' dentist providing such services shall be required to comply with the annual renewal requirements of the Kansas dental board.

(e) The Kansas dental board may adopt rules and regulations as necessary to carry out the provisions of this section, *except that no such rule and regulation shall alter or affect the intent of paragraph (2) of subsection (a).*

(f) This section shall be part of and supplemental to the dental practices act.

Sec. 2. K.S.A. 1999 Supp. 65-1466 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

National Health Service Corps: On the Frontline in KANSAS

A publication of the Kansas Association for the Medically Underserved January, 2000

What is the National Health Service Corps?

The National Health Service Corps (NHSC) is a program of the federal Health Resources and Services Administration (HRSA) that assists underserved communities in recruiting primary care providers. Enacted in 1970 through the Emergency Health Personnel Act, the NHSC focuses on the most critical needs. Through this resource scholarships and loan repayment are made available to qualifying providers who agree to work in underserved areas of the state.

Recognizing that the best providers care for both patient and community, the NHSC assists in find the right match. In order to be considered eligible for assistance, communities must be designated by the federal government as Health Professional Shortage Areas or (HPSA's). Eligible providers include Primary Care Physicians, Psychiatrists, Dentists, Nurse Practitioners, Certified Nurse Midwives, Physician Assistant's, Masters Level Social Workers, Marriage and Family Therapists and Clinical Psychologists .

Thirty five Kansas providers are currently utilizing this resource at various locations throughout the state, mostly in sparsely rural areas – thus helping achieve 100% Access, one community at a time.

The National Health Service Corps in Kansas

The history of the NHSC in Kansas began in June, 1972, when two physicians were assigned to Miami county. By the end of 1999, 101 physicians, 14 nurse practitioners, 28 physicians assistants, 13 dentists and 15 mental health providers had been matched with Kansas communities. Additionally more than 100 health professional students have served internship or fellowship positions through the NHSC SEARCH program.

Most NHSC clinicians serve in private practice settings across the state. They can also be found providing care in Primary Care Clinics and Community Health Centers, dentists offices and clinics and mental health centers. Their presence offers a vital service to all Kansans and has been a valuable recruitment tool.

NHSC providers are required to serve all clients within the assigned health professional shortage area. This assures access to Medicaid, Medicare and the uninsured, who are charged according to a sliding fee scale.

By combining NHSC recruitment and retention capabilities and other local, state or federal resources, communities can gradually build a core of providers.

Working in partnership, the Kansas Association, the State Primary Care Office and the National Health Service Corps provide a coordinated effort toward alleviating the problem of access. The first step in that process is identification of the Federal shortage areas that qualifies a site for NHSC placement.

WHAT IS A FEDERALLY DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREA?

By the end of 1999, 81 whole or partial Kansas counties were federally designated health professional shortage areas. This included 22 dental , 20 Mental Health and 39 primary care areas in the state.

This means that in each of these areas, the ratio of health professional to population has reachedcapacity –

- Primary Care HPSA
  1 –3500 population
- Dental HPSA
  1 – 5000 population (geographic)
  1 – 4000 population (low income)
- Mental Health HPSA
  1 – 30,000 population.

Joyce Volmut, Executive Director KAMU, Dr. Daryl Callahan, Phillipsburg , and Dr. Don Weaver, Assistant Surgeon General and Director National Health Service Corps. See related story Primary Care Connection Insert)

Once approved, agencies within the HPSA may apply for recruitment assistance from the NHSC. Approved sites are then placed on a list that is available to individuals who have received NHSC scholarships or have requested loan repayment.

The Kansas Association for the Medically Underserved attempts to work closely with Kansas graduates or clinicians who want to stay and work in Kansas.

NHSC Programs Operating in Kansas

Recruitment and Retention Assistance Scholarship Program Loan Repayment
SEARCH – Student/Resident Placement and Experiences in Community Health

Recruitment Assistance

Each year eligible Kansas communities receive assistance from the NHSC in filling primary care vacancies. Eligible for recruitment are ;

- primary care clinicians such as allopathic and osteopathic physicians (family practitioners, psychiatrists, pediatricians, internists, obstetricians/gynecologists (OB/GYNs),
- dentists, dental hygienists,
- nurse practitioners (NPs), physician assistants (PAs), certified nurse-midwives (CNMs), and
- mental health professionals (clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists).

NHSC clinicians are placed in established systems of care that provide a continuum of services which include comprehensive primary care and appropriate arrangements for secondary and tertiary care. Approved NHSC sites must agree to serve all patients regardless of ability to pay and provide a sliding fee discount for persons without insurance based on the federal poverty guidelines.

Interested Clinicians may qualify for NHSC Placement in an approved HPSA location through one of the following programs:

SCHOLARSHIP PROGRAM (SP) A scholar is a clinician who contracted with the NHSC while in training to provide service in a designated HPSA in return for payment of tuition, fees, and a monthly stipend.

To be eligible a student:

* must be a citizen and attending:
* a fully accredited U.S. school of allopathic or osteopathic medicine;
* a fully accredited nurse-midwifery or nurse practitioner program;
* or be enrolled in a fully accredited bachelor's or master's degree physician assistant program.

All funds are considered taxable by the IRS.

For each year of support, students must serve one year in a federally designated HPSA of greatest need upon completion of training . A two year minimum is required but may be extended at the completion of the two year obligation.

LOAN REPAYMENT PROGRAM (LRP) A loan repayor is a clinician who has contracted with the NHSC upon completion of training to provide services in a designated HPSA in return for funds to retire qualifying educational loans. Similar to the Scholarship program, the clinician must fulfill a service obligation to practice full time in a HPSA for a minimum 2-year period.

Upon approval graduates receive a competitive salary, some tax relief benefits, and a chance to make a significant impact on the health status of a community. In order to qualify:

- Applicants must be a U.S. citizen with a valid, unrestricted State license and/or certificate to practice in the approved site state.

Benefits:

- Qualified educational loans are repaid at a maximum $25,000 per year for the initial two-year contract period.
- Additional one-year extensions, for existing qualified educational loans, may be awarded at qualifying sites for a maximum $35,000 per year.
- Plus - a payment equal to 39 percent of the total loan repayments made during the taxable year involved to assist in payment of tax liabilities incurred.
- Plus - a competitive salary and benefit package is offered through the site.

VOLUNTEER A volunteer is a clinician who chooses to serve in a HPSA without having a service obligation; this clinician is under no obligation to the NHSC.

SEARCH - The Kansas SEARCH program provides health professional students with community-oriented, primary care internships in HPSA's and other medically underserved areas of Kansas.

Through ***SEARCH*** health professional students and or residents:

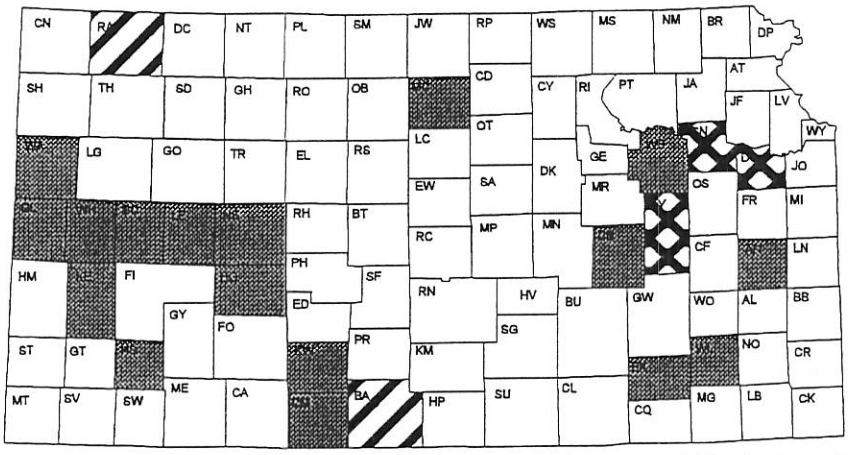
* develop skills, knowledge and attitudes to work effectively and respectfully across cultures
* work in interdisciplinary settings that integrate principals of cultural competency in their system of care.,
* establish professional relationships with persons from diverse backgrounds,
* Gain an appreciation for the diverse geographic conditions of Kansas and it's relationship to primary care

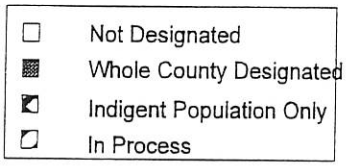
SEARCH is open to the following students: family nurse practitioner, physician assistant, marriage and family therapy, masters-level social work, medical students and primary care residents.

Students must have completed two semesters of course work to be eligible. A minimum of one month rotation is required. National Health Service Corps Scholars and students training in Kansas receive priority. Out of state students are also encouraged to apply .

Participating students receive stipends to help cover costs during the rotation. Sites include Primary Care Clinics and Community Health Centers as well as other sites where NHSC Scholars or Loan repayment recipients are employed. Sites must serve all persons regardless of ability to pay .

Federally Designated
Dental Health Professional Shortage Areas





As of September, 1999, 20 counties were wholly or partially designated as Dental Health Professional Shortage areas.

Currently four NHSC Dentists are employed in Kansas communities
Velma Jo Dennis, DDS Flint Hills Community Health Center, Emporia
Bradley Ross Jenkins DDS Jenkins Dentistry, Dighton
Brian Howard Jenkins DDS Jenkins Dentristry Scott City
Jason Matthew DDS Jon S. Wheat Dental Practice Lakin
Two sites recently added to the Dental List are:
Rachell Richman DDS The Martin de Porres Clinic – Topeka
Rawlins County Dental Clinic, Atwood

Listed as the highest need in the state by communities who participated in the Celebrating Kansas Ceremony, access to dental care remains critical and a legislative priority for KAMU.

What are the facts?

- There has been a 50% reduction in tooth decay – but only for the middle class.
- 80% of tooth decay occurs in only 25% of the Nations children and adolescents.
- Dental caries is the most prevalent chronic childhood disease. Over 50% of children nationally have dental caries in their primary teeth by first grade.
- By age 45, the average person has 30 surfaces affected by tooth decay.
- Oral cancer is the sixth most common form of cancer.
- An estimated 5-10% percent of preschool-age children have baby bottle tooth decay/early childhood caries, a severe form of tooth decay.

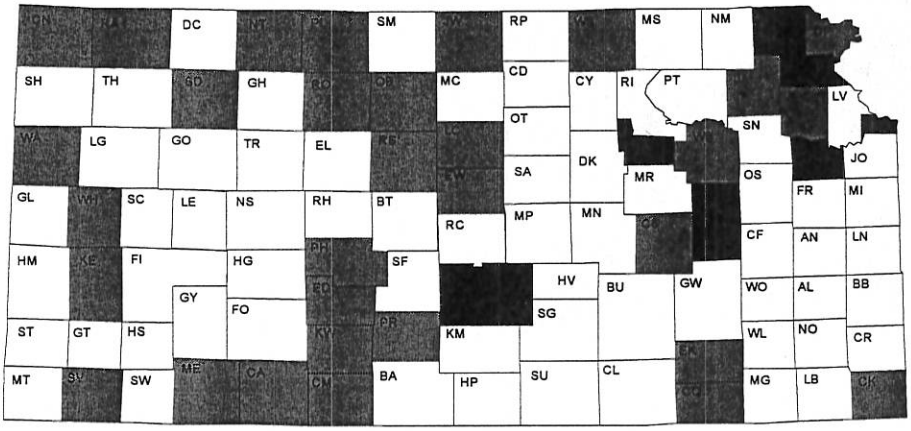
⇒ *The percentage of dental caries climbs to 20% of children from families with low income*

⇒ *The percentage of dental caries is 43% of children in some American Indian populations*

- As many as 52 million school hours are missed annually by children because of oral health problems.
- Nationwide 50% of homebound elderly have not seen a dentist in over 10 years.
- *In Kansas the elderly and families with incomes below $35,000 are most at risk for not having dental insurance.*

Kansas Health Professional Shortage Areas 1999

Darkened areas are full county geographic HPSA's
Striped areas are population HPSAs



National Health Corps Scholarships and Loan Repayments are available in Federally designated HPSA's. *Through this resource in 1999, KAMU assisted in placement or in helping the following providers remain in the state.*

Linda Burdett FNP Kiowa County Hospital Greensburg
Darnell Ganley, FNP Sheridan County Hospital, Hoxie
Lisa Yost, PA Wichita County Hospital , Leoti
Janette Freeman, PA Minneola Hospital Minneola
C.J. Dark PA Minneola
Jay Ciotti, MD Flint Hills Community Health Center Emporia
Mark Alan Gerstberger DO Lakin
Karen Bruck MD MD Minneola
Sheri Lynn Floyd PA Eudora
Scott Ketcher MD Junction City
Kevin Dishman MD Atchison
Mary Miller, MD Cheyenne County Family Clinic, St. Francis
Wade Babcock PA Kepka Family Practice Clinic. Kinsley * Pending
Richard Fitzgerald, DO Westside Family Practice, Holton *Pending
Terry Hadley MD St. Joseph Health Care, Larned *Pending
Chris Hanson PA Wallace County Family Practice, Sharon Springs *Pending
David Short PA Wm Newton Hospital Sedan *Pending
Kayla Keuter, PA Sedan Rural Health Clinic Sedan *Pending
Cecelia Noll, FNP Kiowa Hospital , Greensburg *Pending
Ann Grant MD Smith Hospital Smith Center *Pending
Daryl Callahan MD Phillipsburg
Mary Beth Van Roekel NP Great Plains Health Alliance Phillipsburg
John Bagley PA Health Care Associates Phillipsburg
Betty Ann Pletcher NP Hoxie Medical center, Hoxie
Eric Aspinwall MD Douglas Community Health Center, Kansas City KS
Judith Klingensmith NP Douglas Community Health Center Kansas City KS

Total Family Practice Providers currently completing NHSC obligation in Kansas communities:
11 – Physicians
6 – NP
6-PA

Kansas Association for the Medically Underserved — ***The State Primary Care Association***

Staff:

JOYCE VOLMUT
Executive Director
jvolmut@idir.net

MARY LUNA
Office Manager
mluna@idir.net

SUZANNE GIERSCH
Clinical Coordinator
sgrn@idir.net

DARYL RUTSCHMANN
Community Development Coordinator drutsch@idir.net

EMILY PRICE
AmeriCorps/HealthWave Outreach eepr@idir.net

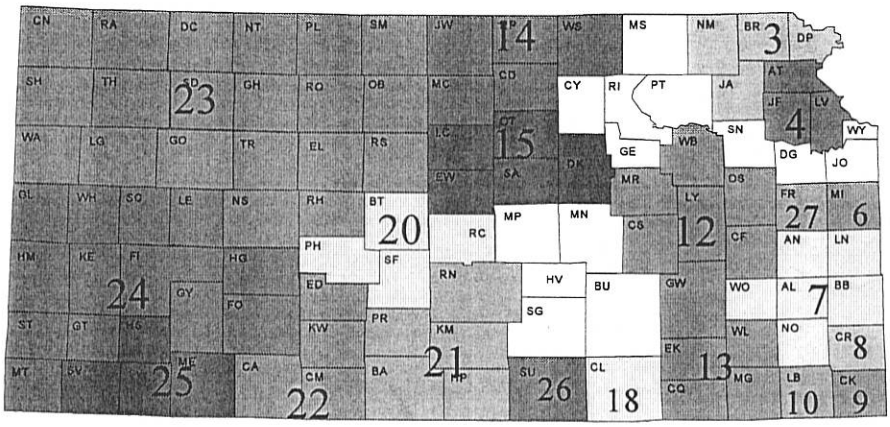
JUDY EYERLY
SEARCH and Legislative Coordinator
jeyerly@idir.net

Office:
112 SW 6th, Suite 201
Topeka, KS 66603

Voice 785-233-8483
Fax 785-233-8403

Web Site:
www.ink.org/public/kamu

Kansas Federally Designated Health Professional Shortage Areas in Mental Health – 1999



Mental Health Providers currently receiving loan repayment or scholarship placement through the National Health Service Corps are:
Kathleen Sherlock SW High Plains Mental Health center, Hays
Alan Betts, SW United Methodist Youthville, Inc., Hays
Karen Brudin Melster Marriage and Family Therapist (FMT), Hays
Theresa Boos SW United Methodist Youthville, Inc., Hays
Diane Sadowski SW Franklin County Mental Health, Ottawa
Merle Sturm SW High Plains Mental Health Center, Osborne
Martin Ward Clinical Psychologist Pawnee Mental Health Center Concordia
Jodie Wenger SW High Plains Mental Health Center, Phillipsburg
Paul Daniels Clinical Psychologist, Fort Scott
Carol Kummer SW Liberal * Pending
Mark Haslett MD Psychiatrist Labette Center for Mental Health, Parsons

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION
BUREAU OF PRIMARY HEALTH CARE
NATIONAL HEALTH SERVICE CORPS
COMMUNITY SUPPORT BRANCH

INSTRUCTIONS FOR COMPLETING THE YEAR 2000 NHSC RECRUITMENT AND RETENTION ASSISTANCE APPLICATION

1. **Practice Site**: Name, address, telephone number, and e-mail address of site requesting recruitment assistance for a full-time NHSC clinician(s). The U.S. Congressional District number(s) and type of practice at site. (A separate application is required for each site location.)

2. **Sponsoring Agency**: Name and address of sponsoring agency, if different from practice site.

3. **Recruitment Contact**: Name, telephone, fax, and e-mail address of individual responsible for recruitment.

4. **Mailing Address:** Name, and mailing address of the Executive Director if different from the site address.

5. **Staffing Levels**: Enter the total number of budgeted full-time equivalent providers and those currently on staff; the number of requested providers by specialty, for the period May 1999 through August 2000, for which NHSC assistance is requested and active recruitment will be undertaken; the projected hire date.

   5a. List the name(s) of the specific individual for whom NHSC loan repayment is requested, if applicable.

6. **Total Users In Previous Calendar Year:**: Provide the total number of active users of the site in the previous calendar year. Indicate totals, if applicable, for primary care, dental care, and mental health services. Provide pro-rated or estimated annual totals if the site was not operational for the entire previous calendar year. Of the total number of users, provide the number of all current users with incomes below 200 percent of the current Federal poverty income level. For new start-ups estimate the number of users anticipated for the next year.

7. **Site's 5-Year Average**: Please provide either the site's 5-year average infant mortality rate or the site's average percentage of low birthweight births. If not available, use the county data.

8. **Nearest Available Site:** Using the transportation mode available to an improverished individual, indicate the name, distance and travel time to the nearest source of outpatient based primary health care (dental or mental health, if appropriate) which offers a sliding fee scale to patients with limited financial resources.

9. **Signature of Site Official and date**.

10. **Signature of State Health Official and date**.

11. **Agreement for All Participating NHSC Sites**.

    a. Insert site name.
    b. Print or type name of Site Official
    c. Signature of Approving Site Official, title, and date.
    d. Signature of Approving Field Office Representative and date.

* **NOTE: It is extremely important that the projected hire date for all clinicians be as accurate as possible.**

NHSC USE ONLY
HPSA TYPE_____
HPSA ID # _____
BCRR # _____

YEAR 2000
NHSC RECRUITMENT AND RETENTION ASSISTANCE APPLICATION

1. *Practice Site:* _____

Street Address: _____

City: _____ *State:* _____ *Zip:* _____ *County:* _____

Telephone Number: _____ *Fax:* _____

E-Mail Address: _____

U.S. Congressional District Number: _____

Type of Practice: BPHC Funded _____ *Other Non-Profit* _____ *For Profit* _____

IHS _____ *BOP* _____ *INS* _____ *OTHER PUBLIC* _____

2. *Sponsoring Agency:* _____

Street Address: _____

City/State/Zip Code: _____

3. *Recruitment Contact:* _____

Telephone: _____ *Fax Number:* _____

4. *Mailing Address (if different from site address):*

Executive Director _____

Street Address _____

City _____ *State* _____ *ZIP Code* _____

OMB Control Number: 0915-0230
5CFR 1320.5(b)

11. ***AGREEMENT FOR ALL PARTICIPATING NHSC SITES***

11a. *We*_____, *agree to:*

Site Name and Address

A. Use a sliding fee schedule and/or other documentable method to reduce fees that assures no financial barriers to care exist, which includes accepting assignment of "Medicare" and entering into an agreement with the State agency that administers "Medicaid."

B. Conspicuously post or otherwise prominently advertise a statement expressing that no one who is unable to pay will be denied access to services.

C. Have a policy of non-discrimination based upon race, color, national origin, disability, or religion.

D. Agree to ensure that at least 80 percent of the patients served are residents of the HPSA in which the practice is located.

E. Provide culturally appropriate ambulatory primary health, dental health, and/or mental health care services.

F. Use a credentialing process which, at a minimum, includes reference review, licensure verification, and a query of the National Practitioner Data Bank (NPDB) of those clinicians for whom the NPDB maintains data.

G. Function as part of a system of care which either offers or assures access to ancillary, inpatient, and specialty referrals.

H. Adhere to sound fiscal management policies and adopt clinician recruitment and retention policies to help the patient population, the site, and the community obtain maximum benefits from the site.

I. Pay NHSC clinicians a salary and benefit package, including professional liability coverage (which must include tail coverage), at least equal to those that would be offered to a comparably trained and experienced civil service employee of the United States Department of Health and Human Services, if the NHSC clinician signs a Private Practice Assignment (PPA) Agreement. (See PIN 99-06 for definition of PPA)

J. Require NHSC clinicians to maintain a full-time clinical practice, working a minimum of 40 hours per week for at least 45 weeks per year.

K Support clinicians with funding and arrangements, including clinical coverage, for their time away from the site to attend NHSC sponsored meetings and other continuing education programs.

L. Communicate to the Health Resources and Services Administration Field Office any change in site or clinician status that might adversely affect the site or a clinician continuing an established relationship with the NHSC.

M. Maintain and make available for review by NHSC representatives all personnel and practice records (including Uniformed Data System) associated with an NHSC clinic including documentation which contains such information that the Department may need to determine if the individual has complied.

N. Adhere to cost sharing requirements as listed in section 334 of the PHS Act.

Signatures below are assurance that this application contains true and correct information and that the site agrees to comply with all of the previous listed points of this agreement.

11b. Name of Site Official: _____

11c. Signature of Approving Site Official: _____

Title: _____ **Date:** _____

11d. Signature of Approving Field Office Representative _____ **Date:** _____

5. **Staffing Levels**

PHYSICIANS	STAFFING LEVEL		NUMBER OF NHSC PROVIDERS REQUESTED	PROJECTED HIRE DATE			
	FULL	CURRENT		MAY-AUG 1999	SEPT-DEC 1999	JAN-APR 2000	MAY-AUG 2000
Family Practice OB Required? Yes / No							
Internal Medicine							
Pediatricians							
Obstetrician/Gynecologists							
Psychiatrists							
NURSE PRACTITIONERS							
Family Nurse Practitioners							
Adult Nurse Practitioners							
Geriatric Nurse Practitioners							
Pediatric Nurse Practitioners							
Women's Health Nurse Practitioners							
Psychiatric Nurse Practitioners							
OTHER DISCIPLINES							
Physician Assistants							
Nurse Midwives							
Dentists							
Dental Hygienists							
Clinical Psychologists							
Clinical Social Workers							
Psychiatric Nurse Specialists							
Marriage & Family Therapists							

5a. **Proposed Loan Repayors: Name, Discipline/Specialty**

_____ _____

_____ _____

6. **TOTAL USERS IN PREVIOUS CALENDAR YEAR:**

Primary Health Care_____ Dental Health Care_____ Mental Health Care _____ TOTAL _____

Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

7. Site's 5-year Average Infant Mortality Rate _____ Site's 5-year Average Percentage of Low Birthweight Births _____

8. Indicate the distance, and travel time to nearest source of primary care, dental care, or mental health care site using available public transportation. Please list information below:

NEAREST AVAILABLE SITE NAME AND ADDRESS	MILES	TRAVEL TIME

9. Signature of Site Official: _____ Date: _____

Title: _____

10. Signature of State Health Official: _____ Date: _____

Title: _____

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

112 SW 6th Ave., Suite 201 Topeka, KS 66603 785-233-8483 Fax 785-233-8403 www.ink.org/public/kamu

Fact Sheet
Dental Care Kansas

- 32% of all respondents surveyed had not seen a dentist in the last year.
- Most at risk for not seeking dental care were:
  Members of Households with incomes below 35,000.
  Hispanic and African-American populations
- 15-25% of all age groups reported they currently needed dental care. This was identified as fillings, dentures, partials, teeth pulled, caps, crowns and root canals.
- 30-40% of all age groups stated they were without dental insurance.
- Most at risk for being without dental insurance were elderly (70%) and young adults (40%)

Kansas Department of Health and Environment
Behavioral Risk Factor Surveillance System 1996

KANSAS DENTAL ASSOCIATION

Date: March 8, 2000

To: House Committee on Health and Human Services

From: Kevin J. Robertson, CAE
Executive Director

RE: Testimony on HB 2990 (Dental Clinics)

Chairman Boston and members of the House Committee on Health and Human Services, I am Kevin Robertson Executive Director of the Kansas Dental Association. The Kansas Dental Association consists of approximately 1,000 members, representing 80% of Kansas' practicing dentists.

The KDA is in agreement that some changes are necessary in the current law in order to better meet the dental needs of Kansas' lowest income citizens. As such, the KDA finds the statutory changes contained in HB 2990 to exempt federally qualified health centers (FQHCs) to eliminate the conflicts between state law and federal requirements to be acceptable. In fact, the KDA would also be amenable to changes in the law to clarify that Healthwave enrollees and Medicare patients are eligible for treatment in clinics.

With this having been said, the KDA would like the Committee to consider an amendment to HB 2990 to require FQHCs to report to the Heath Care Reform Legislative Oversight Committee detailing the income levels and insurance status of their patients an annual basis. This proposed amendment is attached. It is not intended to create a burdensome requirement for the FQHCs as it is our understanding the Kansas Association of Medically Underserved already compiles such information. Since HB 2990 exempts FQHCs from the law, the reporting would provide the legislature with some oversight of their activities.

Let me point out for clarification that that Kansas law does not currently limit who a health clinic in Kansas can treat. The Kansas Dental Practice Act does, however, limit whom a licensed Kansas dentist can treat in a health clinic practice setting. There are FQHCs in Kansas that employ a dentist under current law. The risk to these clinics, however, is that they could lose their federal funding. To my knowledge this has not occurred to date.

The KDA does not support blanket removal of the restrictions on all clinics. The KDA has been very active working to find solutions to Kansas access issues for our lower income citizens. We have been a positive and willing participant in no fewer than 10 meetings and conferences across the state and around the country in 1999. The KDA is working to encourage more dentists to participate in Medicaid, we are actively working with the Department of SRS to adjust the Healthwave and Medicaid programs to better meet both patient and dentist needs. At all of these meetings representatives of various health clinics, and Federal and State agency officials, argued that the conflict between Kansas law and the federal rules governing FQHCs make it

5200 Huntoon
Topeka, Kansas 66604-2398
Phone: 785-272-7360
Fax: 785-272-2301

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nearly impossible for FQHCs to find and hire. dentists to work in these clinics. The KDA heard and thoughtfully considered this information. At its meeting on November 5, 1999, the KDA amended its policy regarding health clinics and voted to accept changes in Kansas law exempting FQHCs.

Some proponents may argue that the 200% of poverty restriction is problematic for a variety of reasons. This situation, however, is no different for health clinics than it is for recipients of HealthWave or even Kansas Medicaid. In each of these cases, Kansas policy makers have made a decision as to who is qualified to be treated in these programs or settings. These policy makers have drawn a definitive line with regard to income separating those who can receive care with public assistance versus those who cannot. The KDA does not believe the laws governing health clinics should be any different.

Clearly, there is a need for greater access to dental care in Kansas. Expanding the ability of all health clinics to treat all patients will not meet this need. If clinics do not currently have the facilities to treat patients with incomes of 200%, even 150% and below of poverty, expanding the patient base will only make it more difficult for the most needy of patients to receive care. The KDA fears that an expansion of all clinics to treat anyone regardless of ability to pay, will only shift care away from those who are most in need.

Thank you for the opportunity to testify on HB 2990. I will be happy to answer any questions you may have at this time.

Amendment offered by the Kansas Dental Association

HOUSE BILL No. 2990
By Committee on Appropriations
2-16

AN ACT relating to the dental practices act; amending K.S.A. 1999 Supp. 65-1466 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1999 Supp. 65-1466 is hereby amended to read as follows: 65-1466. (a) *(1)* Notwithstanding any other provision of the dental practices act, a not-for-profit corporation having the status of an organization under 26 United States Code Annotated 501(c)(3) which is also a facility qualified under subsection (b) of K.S.A. 65-431 and amendments thereto to select and employ professional personnel, an indigent health care clinic as defined by the rules and regulations of the secretary of health and environment, ~~a federally qualified health center,~~ or a local health department may employ or otherwise contract with a person licensed under the dental practices act to provide dental services to dentally indigent persons.

(2) Notwithstanding any other provision of the dental practices act, a federally qualified health center may employ or otherwise contract with a person licensed under the dental practices act to provide services to any person, except that a federally qualified health center shall be required to provide a report to the Health Care Reform Legislative Oversight Committee indicating the income level of their patients, and the percentage of patients covered by dental insurance in the preceding year.

(b) Dentally indigent persons are those persons who are: (1) Determined to be a member of a family unit earning at or below 200% of poverty income guidelines based on the annual update of ``poverty income guidelines'' published in the federal register by the United States department of health and human services and are not indemnified against costs arising from medical and hospital care or dental care by a policy of accident and sickness insurance or an employee health benefits plan; or (2) eligible for medicaid; or (3) qualified for Indian health services. This subsection shall not be construed to prohibit an entity under subsection (a) which enters into an arrangement with a licensee under the dental practices act for purposes of providing services to dentally indigent persons pursuant to subsection (a) from defining ``dentally indigent persons'' more restrictively than such term is defined under this subsection.

(c) A licensee under the dental practices act who enters into an arrangement with an entity under subsection (a) to provide dental services pursuant to subsection (a): (1) Shall not be subject to having the licensee's

PRACTICE LIMITED TO PERIODONTICS

KELLY D. DOUGLASS

DDS MS PA

March 8, 2000

Chairman Boston, and members of the Committee, I am Dr. Kelly Douglass, a periodontist practicing here in Topeka and President of the Kansas Dental Board. I am speaking today regarding the Dental Board's position regarding House Bill 2990.

As you are aware, one of the mandates of the Dental Board is to help provide protection for the public in dental matters. This protection is often twofold, the first being protection against harm by those providing dental services, and the second being to help facilitate access to those services by the public.

The concept of this bill is intended to address the second portion of this responsibility, and allow federally qualified health centers to be in compliance with federal mandates. We understand this need and feel it is a valid one. It is well known that the indigent population of Kansas is in need of safe dental care and the Dental Board is on record in support of measures to accomplish this. Although this would allow non-indigent patients to access treatment, we understand the need to comply with federal guidelines and accept this limited change in the philosophy that only an "employer" licensed dentist should make decisions of patient care and not be an employee of a non-licensed person.

The Dental Board believes it is important for it to retain its authority to carry out the process of Rules & Regulations. On page 2 of the bill, starting in line 15, language is added by the proposed statutes of, "except that no such rule and regulation shall alter or affect the intent of paragraph (2) of subsection (a)." If the intent of this addition is to prevent the Dental Board from removing the authority of federally qualified health centers from employing persons licensed under the dental practices act to provide services to any person, we would agree to this restriction of Rules & Regulations. If the intent goes beyond simply allowing these federally qualified health centers from employing these persons, then the Dental Board would strongly object to this restriction. The Dental Board believes in state control of its licensees and does not support relinquishing this control to the Federal Government.

Once again, the Dental Board acknowledges the need for the proposed legislative changes in HB 2990. I ask that you maintain the language presented in the current form of this bill, which ensures access to safe care for the population to be determined by dentists and not nonprofessional corporations other than the exception of federally qualified health centers, and that you maintain the regulatory function of the Dental Board over this care and those providing it. I would be happy to address any questions you might have at this time.

Thank you for your consideration.

3033 SW VILLA WEST DR. TOPEKA, KS 66614 • PHONE: 785·272·0770 • FAX: 785·272·0035 • E-MAIL: KDDDDS@IX.NETCOM.COM

H&HS
3-8-2000
Atch #3

KSNA
KANSAS STATE NURSES ASSOCIATION
the Voice of Nursing in Kansas

1208 SW Tyler
Topeka, Kansas 66612-1735

785.233.8638 * FAX 785.233.5222
www.nursingworld.org/snas/ks

Emma Doherty, M.A.
President

For More Information
Terri Roberts 233-8638
March 8, 2000

H.B. 2990 Dental Practice-Increasing Access to Dental Services

Chairperson Boston and members of the House Health and Human Services Committee, my name is Vickie Armstrong, R.N. and I work at Shawnee County Public Health Department and I am here to support H.B. 2990 on behalf of the Kansas State Nurses Association.

Having healthy teeth is important, it makes you feel good about yourself, it gives you fresh breath and a nice smile. Poor dental care can lead to major health problems in adulthood. Registered nurses as front line care-givers see children and adults whose dental care is so inadequate that it interferes with their self concept (particularly in children); health in general, because of chronic pain or malnutrition or a combination of both of these.

Although the American Dental Association recommends that adults should see a dentist for routine dental care and oral hygiene counseling at least once a year, 62% of health center respondents in a 1998 Kansas survey of three community health centers reported that they had not seen a dentists during the last year. This percent is nearly double the 32% of Kansans surveyed in 1996 who stated they had not seen a dentists during the last year. Low income is a significant risk factor for childhood caries, and the greatest unmet treatment needs are seen in children from families with low incomes.

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Unfortunately, access to a dentists care, either because of manpower shortages or ability to pay are two significant factors for individuals. Kansas currently has twenty-two counties that are wholly or partially designated as Dental Health Professional Shortage areas. The changes proposed in H.B. 2990 will not be sufficient to address the access issues that exist unless the amendments proposed by KAMU are added to this bill. Access to dental services in FQHC's alone will provide access in two cities only, Wichita and Emporia. The changes proposed by KAMU will permit recruitment of dentists to underserved areas as part of the National Health Service Corp, and will provide access for some Kansans seeking dental services in primary care clinics. This proposal is quite honestly one that should be embraced readily as a first step towards providing greater access to dental care for our citizens. This committee has heard in the past about the shortages of dentists and dental hygienist--- perhaps a comprehensive evaluation of dental health professionals education and training to meet the needs of our state is in order*. We know that there are not enough dentists or dental hygienists to care for everyone in Kansas, especially the indigent, we ask your support of H.B. 2990 with the proposed amendments.

**In the middle 1970's such a study was conducted on NURSING EDUCATION in Kansas. That study commonly referred to as the 1202 Commission Study of Nursing Education has served the profession well and forced dialogue and debate on significant education, distribution and manpower issues that while not completely resolved, have dramatically improved as a result of that study and the implementation of its recommendations.*

March 8, 2000

Rep. Garry Boston, Chair
Health and Human Services Committee

My name is Judy Eyerly and I am here today speaking on behalf of a new non-profit called the Douglas County Dental Clinic. I have also attached a letter from our president, Dr. Ed Manda, a private dentist. Other board members include a dental hygienist; the City Manager; the hospital CEO; the Sheriff; representatives from the health department, the University of Kansas, and Haskell Indian Health Service; and other private citizens. We recently received 501(c)3 status and are working hard to make dental care accessible in our community. A list of our board members is attached.

Currently the only way to receive dental care in Douglas County is:

- to have private dental insurance and be able to afford the co-pay;
- have access to the 1.2 FTE dentists who see patients through publicly funded programs such as Medicaid;
- be able to pay all expenses out of pocket at the time of service;
- have an established relationship with a dentist who will allow you to make payments;
- or be able to prove the required percentage of Native American blood that will give you access to Haskell Indian Health Service.

According to a State analysis, approximately 37% of the county has difficulty accessing dental care by one of the above methods. The analysis done by the state lead the federal government to declare that Douglas County is a Dental Health Professional Shortage Area.

My main area of concern in coming before you today is the restrictive language that remains in HB 2990. The language in this bill effectively kills any chance we have of creating a viable dental clinic in Lawrence. With a primary mission to serve patients who lack access due to economic reasons, the Board is currently working on what mix of patient revenue we need in order to be viable and stay true to our mission. Although I cannot give you specifics yet, of this we are certain: *we will need patients with all forms of insurance, and patients who can pay out of pocket - including patients over 200% of*

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poverty - to help offset costs for patients who cannot afford to pay or who are on a sliding fee scale. We obviously cannot guarantee what mix of patients will come to our clinic, but we need to remain open to all possible revenue sources.

The reason this mix of revenue is important is that private foundation or government funding is almost nonexistent for a free standing dental clinic. Knowing this, our community is still committed to doing what we can to improve access to dental care. We are asking you to partner with us and remove the restrictive language in the Dental Practice Act that would prevent our community from realizing our goal. We support the amendments to this bill that the Kansas Association for the Medically Underserved has made, but would ask you to go further and also remove the below 200% of poverty restriction. Surely there is a way to do this that the Dental Association could agree with - for example aren't there sunset provisions where you try something for a couple of years and evaluate it to see what sort of impact it has had? That's what was done when the practice act was changed to allow clinics to hire dentists in the first place.

Yesterday, another private dentist in Lawrence called to give permission to use his name as a supporter of removing all restrictive language from the dental practice act. Dr. Robert Jacobs is one of two pediatric dentists in the county and he sees the majority of children on Medicaid. A couple of weeks ago my own dentist suggested to me that if there was any dentist in Douglas County who might see a non profit clinic as competition it would be Dr. Jacobs because of the his pediatric specialty. But he does not - he is very aware of the tremendous need that exists that is not being met in a traditional private practice and also understands the need for a clinic to have a variety of revenue in order to survive. As with other private dentists who are supportive, he sees this as just plain common sense.

I would like to close with a quote from a letter that John Hay, a private dentist, wrote in support of removing all of the restrictive language: "As a Kansan and a dentist I would be proud to see our state and profession do the right thing in increasing access to care."

Thank you for your time today.

Douglas County Dental Clinic
Lawrence, Kansas

Board of Directors

Ed Manda, DDS, private practice

Donnetta Bouton, Dental Hygienist

Jim Boyle, University of Kansas

Mike Kincaid, DDS, Haskell Indian Health Services

Barbara Schnitker, Director of Nursing, Lawrence/Douglas County Health Department

Loren Anderson, Sheriff

Gene Meyer, CEO, Lawrence Memorial Hospital

Mike Wildgen, Lawrence City Manager

Lt. Kirk Schuetz, Salvation Army

Donna Osness, Retired Prinicipal, Riverside School

Phyllis Lemmon, private citizen

Judy Eyerly, private citizen

EDWARD A. MANDA, DDS

6 March 00

To Whom It May Concern,

I'm please to write and ask your support of HB 2990 to allow dentally indigent clinics, or not-for-profit charitable dental clinics, to operate by seeing any and all patients in need of care. Access to care is the single most important consideration. No access can be provided without a dentist to provide the very care that is necessary. Recognizing that requirement, it then becomes absolutely necessary to find a funding source great enough to hire a dentist. You can find that grants and other funding sources are becoming limited, and frequently go to medical facilities, so it becomes the responsibility of the dental clinic to provide the majority of funding necessary to attract a dental professional.

The second issue to consider, although not nearly as critical as access to care, is the infringement such a clinic is thought to have on those nearby traditional dental practices. Competition is suggested when patients are "lured away" from nearby offices. In reality, anyone will recognize that if patients leave a practice because of cost alone, they are the patients who are better suited for a charitable clinic and should be congratulated for seeking dental care in the first place. Douglas County has a federal HPSA designation that is beyond embarrassing, because dentists are not currently treating nor will volunteer to treat indigent patients. Yet in this university town there is thought to be an oversupply of dentists, so implied competition exists anyway. Therefore, patients who are better able to pay for the care that they wish to receive, yet who chose to visit a charitable clinic, probably left the traditional office because the doctor-patient relationship was not sufficient to retain that patient. When it comes to fee-for-service healthcare, there should always be freedom of choice.

Without question, the major objective of HB2990 should be to promote access to care for the dentally indigent. Funding becomes the means to that end. By allowing the income potential of a not-for-profit clinic to provide a majority of it's funding, HB2990 will simplify the not-for-profit clinic's ability to sustain itself. It's a win-win situation for all.

Thank you for your consideration.

Ed A.

330 Maine Street Lawrence, Kansas 66044 785/841-1400 Fax 785/841-3212

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Family Dental Care

John H. Hay, D.D.S.
10 East 9th Street, Suite C/D
Lawrence, KS 66044
(785) 749-2525

Representative Gary Boston
Chairman: Health and Human Service Committee
February 8, 2000

Dear Representative Boston:

I am writing to you to voice my support of HB2586. As a licensed, practicing dentist for nearly 13 years in the State of Kansas, I have seen firsthand the need for increased access to dental care in our state for lower income individuals. I have witnessed the reduction in numbers of Medicaid providers for our children as well as the bare bones attempts to treat adult urgent care needs through volunteer efforts.

While I am a general practicioner in a private setting and not a public health specialist, the facts are plain and simple. There is a significant portion of our population that does not have access to basic services within their budget.

I am a member of the Kansas Dental Association and previously served on their executive council but I am in disagreement with their premise that the relaxed guidelines proposed by HB2586 is a threat to independent practice. Patients who would benefit from and frequent "sliding fee" or "indigent" care clinics do not make up private practice "fee for service" client bases. These patients are turned away or receive emergency care only due to their inability to pay.

While I am very much in favor of dental practices being owned only by licensed dentists and would vigorously oppose the "for profit" ownership by 3rd party entities (ie: national retailers, insurance companies), anyone who thinks that these indigent clinics threaten their private practice is suffering from either delusions or paranoia.

I would welcome a place to refer people in my community to where a reduced fee setting allowed them to obtain basic preventive and therapeutic care. As a Kansan and dentist I would be proud to see our state and profession do the right thing in increasing access to care. Thank you for your time in considering my point of view. While I was not able to testify in person, I would welcome you sharing my viewpoint with the rest of your committee.

Respectfully,

John H. Hay D.D.S.

Note to committee:

This letter was written in support of the original Bill that removed all restrictive language in the dental practice act.

THE HUNTER HEALTH CLINIC, INC.

2318 EAST CENTRAL - WICHITA, KANSAS 67214 - TELEPHONE (316) 262-3611
FAX (316) 262-0741

"A Community Health Center"

Testimony in favor of HOUSE BILL No. 2586

A Federally Qualified Health Center: The Hunter Health Clinic receives federal funding to provide primary health care services to all people, regardless of ability to pay. To be eligible for this funding, the clinic must be a non-profit, community based organization located in a Medically Underserved Area (MUA). The clinic must also generate patient revenues.

Practically Speaking: Hunter Health Clinic serves as a "safety net" for those who cannot access health care because of economic, cultural or linguistic barriers. It is our mission to provide medical and dental care to the medically underserved. We have provided dental services for nearly 20 years. We are a "gap filler". The largest gap in dental services that Hunter Health Clinic currently fills is emergency dental care for uninsured adults, because Medicaid does not cover adult dental care.

1995 to present: When I testified on this matter in 1996, Hunter Health Clinic was providing dental services to nearly 2,000 patients per year. 97% were uninsured, 14% were homeless, 15% had severe mental illness or alcohol/substance abuse problems and 15% required translation services. From 1997-1999 we maintained services to the uninsured, but the homeless increased to 22% and patients needing translation increased to 26%.

We are not a threat: Because FQHC's serve a target population that cannot easily access the typical dental practice, there should be no reason for the typical dental practice to feel threatened by our continued service.

The Dental Practices Act in its current form:

a. **Penalizes Underinsured Patients:** Insured Kansans who cannot afford high deductibles are no different from the uninsured, but they must be turned away. Turning away underinsured persons is not in keeping with our mission to serve all people, regardless of ability to pay.
b. **Restricts Access for the Difficult to Reach:** Insured Kansans who need translation, transportation and medications assistance must be turned away.
c. **Adversely Impacts Community Health:** Limiting access to an FQHC or other indigent dental clinic, causes the medically underserved to go without dental care, resulting in mental anguish, poor nutrition and life threatening infections.
d. **Takes Away The Patient's Right to Choose:** Insured Kansans do not have the right to choose an FQHC as their dental care provider.
e. **Hinders Recruitment Efforts:** We are currently without a dentist. The Dental Practice Act in its current form is a hindrance to our recruitment efforts.

We support the bill as amended: As amended, the bill would allow Hunter Health Clinic to employ or contract with a licensed dentist to provide dental services because we are a federally qualified health center (FQHC).

Contact: Susette Schwartz, CEO, CEO-HHC@swbell.net, **(316) 262-3611**

"Let us put our minds together and see what life we will make for our children"

H HS
3-8-2000
Atch #6

Testimony Favoring HB 2990

Cathy Harding, Executive Director
Flint Hills Community Health Center
420 West 15th Ave.
Emporia, KS 66801
(316) 342-4864, Ext. 261
charding@lyoncounty.org

Today I'm here to testify for the passage of HB 2990 as amended with the assistance of the Kansas Association for the Medically Underserved (KAMU).

I'm a "paper pusher—" the Executive Director of the Flint Hills Community Health Center in Emporia. I imagine some of you may be "paper pushers" too, both during and after these months you're serving in Topeka. Because of my position, I'm usually removed from the face to face interaction with our clients. I don't see the mother and sick baby that can't find medical care because they don't speak English. I don't see the 14-year-old girl coming in for a pregnancy test alone, because she's had no family support for years. And I don't see the 3-year-old with decay on every tooth to the gum line because his parents had never really looked in his mouth until now—when he complained about his tooth hurting. But just because I have that cushion of paper around me does not mean I should be allowed to forget that the services we provide—and that you provide, through legislation—are for living, breathing children and families who need our help. Today I am also asking you to never forget.

We opened our Dental Clinic at the Flint Hills Community Health Center in Emporia one month ago. Our decision to commit to this clinic was the result of years of public and professional concern, community needs assessments, and the determination by the Federal government that Emporia is a designated Dentally Underserved Area. No dentist in Emporia—or

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Lyon County—accepts new Medicaid patients. Low-income, uninsured people in our area have had no options for many years.

I'd like to take a minute now to tell you a story. One morning, about a month ago, I arrived at work around 7:45. While walking through our parking lot I noticed a man sitting in an old, dilapidated car near our entrance. Thinking he was waiting for us to open, I walked over to inform him that we don't unlock the doors until 8:30. He replied that he was aware of that, and cheerfully thanked me for my help. He then said he'd heard we have a dentist, and wondered if that was right. I acknowledged our new dental program, and he stated he was here to make a dental appointment. I suggested that, since it was cold, he could just as easily call for an appointment, but that he was certainly welcome to stay. Nearly 30 minutes later, as I was leaving for a meeting, I noticed the man still sitting in our parking lot, waiting.

Later that day, I asked Dr. Dennis (our Dental Director) if a man had come in to make an appointment shortly after we opened. "Yes, he did," Dr. Dennis replied. "But he was here to make the appointment for his two elderly parents, and they have Medicare. I had to turn them away." Now, let's think about this. A middle-aged man sits alone in the cold, for more than 45 minutes to get help for his parents and, because of the language in the existing law, he's told that they can't be helped. I am here today to tell you that there is something terribly wrong with this picture.

The day our Dental Clinic opened we had a waiting list of over 200 people. We'd had to turn away more than twice that number because of the restrictive language in the current Kansas Dental Act. In order for non-profit clinics such as ours to truly help the people of this state, we *must* be able to provide dental services to people with Medicare. We *must* be able to serve low-

income people with health insurance. We *must* be able to provide dental care to children with Health Wave. Simply put, we *must* be able to serve the people who need our help.

You may, at some point in this debate, hear testimony that passage of HB 2990 will allow clinics such as mine to "steal" paying clientele from private dentists. Let me give you the real story. When you pass this bill, it will open doors for thousands of people who live every day of their lives in pain. It will empower the hardest of the hard to employ that can't get a job because of tooth decay and the breath associated with that decay. It will allow those of us with conviction and desire to teach uninformed parents how to clean their babies' teeth, so we won't have the 3-year-old with a mouth full of decay.

I urge you to recommend passage of House Bill 2990 as amended. By doing so you will have the gratitude of hundreds of people in Lyon County, and thousands throughout this state.

TESTIMONY REGARDING THE DENTAL PRACTICE ACT

BARBARA STEVKO, M.D., M.P.H.
HEALTH OFFICER, SHAWNEE COUNTY HEALTH AGENCY

MARCH 8, 2000

Language in the existing Dental Practices Act (65-1466) unfairly restricts access to dental care for Kansas residents.

- There is an enormous need for dental care for the indigent and working poor in Kansas.
- Clinics that provide medical care to this population, are required by funding sources to provide basic dental care. Funding sources mandate that care be available on a sliding-fee scale, without restriction as to who can seek care. Failure to have open enrollment limits federal funding as well as recruitment of dentists.
- This statutory provision is professionally and ethically unconscienable.
- State requirements undermine continuity of care, especially for people who live on the margin of indigency and move in and out of established income restrictions multiple times during a year.
- Individuals who would use these dental services are currently unserved by private practitioners and would represent no economic loss to them.
- Without a change in the existing legislation, it will remain difficult to impossible to obtain funding and recruit dentists necessary to provide services to the underserved in Kansas.
- Dental services at indigent care and community health centers in Kansas need to be available without patient income or insurance status restrictions. Dental services access should conform to existing access expectations for patients seeking care at community mental health centers and community hospitals.

The unmet need for dental services for low-income residents, the Medicaid eligible and Medicaid enrollees in Shawnee County is enormous. The County was designated a Dental Professional Shortage Area (HPSA) for indigent services in September 1996, by the Department of Health and Human Services. This was based on a low-income population at or below 200% of poverty of 35,624, who were served by 2.4 FTE dentists, a ratio of 14,843:1.

Last year at this time, Shawnee County Health Agency (SCHA) completed a dental needs assessment for our service area and found that there were 3.5 FTE dentists within our service and contiguous areas accepting children on Medicaid and new patients, children and/or adults. The total projected annual dental visits for the area's population is 21,260. The 3.5 FTE dentists were estimated to supply 8,050

visits to patients in the area, leaving 13,210 unsatisfied visits. This leaves a deficit of 5.7 FTE dentists for this population group.

Last year Shawnee County Health Agency applied for Federal funding to add a dental services component to our existing Section 330 Community Health Center. This funding would have established a dental clinic operated by SCHA to provide basic dental services to all, regardless of ones ability to pay. In order to operate such a clinic in Kansas, and not go against our federal mandate, we would have had to have a Public Health Service dentist assigned to our site. Such a dentist would have been able to practice without the restrictions placed on Kansas licensees. However, these assignees are extremely limited. Shawnee County received neither funding or a NHSC dentist. Our unmet need remains.

The existing legislation places an unnecessary burden on organizations who attempt to help the indigent and others who can not afford dental care in the first place. Private dentists do not adequately serve this population and few in Shawnee County actually report that they will accept Medicaid patients. The existing legislation denies or limits funding from grants that could help establish needed dental programs and help maintain them.

For the individual living on the margins of poverty, dental health impacts general health and employability.

- Untreated dental problems can limit employment opportunities, sometimes for purely cosmetic reasons in jobs that require interaction with the general public. Limited employment opportunities increase potential for indigency and need for public assistance.
- Untreated dental problems can impact general health, life expectancy, children's ability to learn, school and work attendance, as well as individual self esteem.
- Good oral hygiene and preventive dental care reduce the need, expense and pain of more costly procedures and repairs.

In Kansas, a person with medical insurance that provides no dental coverage, is denied access to low income, sliding-fee services at a Community Health Center (CHC) or indigent care facility. A senior on a fixed income who needs denture repair but has supplemental health coverage, must be refused service at a CHC utilizing a Kansas licensed physician even though it will mean she must go without care because of her financial situation. She cannot eat properly. Her general health status will deteriorate. There will be increased medical and nursing costs, but no one can intervene with appropriate dental care which she cannot afford.