

**FILLING AN URGENT NEED:
IMPROVING CHILDREN'S ACCESS TO
DENTAL CARE IN MEDICAID AND SCHIP**

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Filling an Urgent Need:
*Improving Children's Access to
Dental Care in Medicaid and SCHIP*

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Executive Summary

Critical inadequacies in access to oral health care in the U.S., particularly in the low-income population, have been a focus of increasing concern in the health policy community in recent years. As understanding of the adverse and potentially tragic consequences of lacking dental care has grown, efforts at the state level to improve low-income children's access to oral health care have gained substantial momentum. In this environment, in October 2007, the Kaiser Commission on Medicaid and the Uninsured and the National Academy for State Health Policy convened a day-long meeting of policy officials and oral health experts to discuss children's access to dental care in Medicaid and the State Children's Health Insurance Program (SCHIP) and exchange information and perspectives on the strategies that have worked best to improve it. Given the primary role of Medicaid and SCHIP in covering children, strengthening these programs is a promising and logical approach to increasing children's access to oral health care.

The 15 experts who participated identified a wide assortment of effective actions that states can take related to each of several key dimensions of children's access to oral health care in Medicaid and SCHIP. In addition, they articulated larger, systemic barriers to access and care that must ultimately be tackled, and considered how Medicaid and SCHIP might contribute. The findings and expert assessments the participants offered are summarized below:

- ***Promote increased provider participation.*** Numerous states have raised Medicaid payment rates for dental care to garner more participation by dentists. Some have sought dedicated funding streams for dental care to insulate dental services from state budget cuts. States have adopted diverse strategies to ease the administrative burdens dentists commonly cite as obstacles to their participation. Vigorous provider outreach and support also emerge as effective mechanisms for building a strong base of participation.
- ***Expand the supply of dental care.*** States have taken a variety of approaches to increasing the supply of dental care available for children without increasing the supply of dentists. These approaches include, but are not limited to: training general dentists to care for children; using technology to link general dentists with specialists who can provide consultation or supervision; paying pediatricians to provide certain care; and using state licensing authority to broaden the scope of practice for some provider types or license new provider types.
- ***Improve dental benefits.*** Improved implementation of the required EPSDT benefit in Medicaid could go a long way to increasing children's access to dental care. Adoption of periodicity schedules for children's dental care would also foster improved access and care. Expansion of SCHIP dental benefits to more closely mirror the comprehensive benefits guaranteed under EPSDT would strengthen access for children in SCHIP. Strong supports to assist families in identifying providers and in scheduling and getting to their children's dental appointments can help lower poverty-related obstacles that prevent low-income children from realizing access to the care that Medicaid and SCHIP cover.
- ***Increase oral health education and patient support.*** Coordinated outreach and oral health education efforts can capitalize on the participation by many low-income families in multiple public programs. Head Start, health centers, local health departments, and other maternal and child health organizations are all platforms for outreach, education about oral health, and early identification of children who need help gaining access to dental care. In addition, states can shape their Medicaid and SCHIP benefits, administration, and delivery systems in ways that improve and more effectively support low-income families' use of recommended

dental care for the children. “Patient navigators,” care coordinators, case managers, and disease management programs in various states help enrollees connect with dentists, remove access barriers, and help them obtain the services they need.

- ***Improve data collection, monitoring, and evaluation.*** To build the case for state action, policymakers need to develop the capability to measure and monitor oral health access and need among low-income children. Similarly, to ensure wise investment of scarce public funds, they need data on both the consequences of inaction and the estimated impacts of interventions they may seek to replicate or adapt. State health surveillance activities that can trigger strategic programmatic investments need to be adequately funded. Evaluations that document the impact of new initiatives can help motivate further improvements, guide future policy, and sustain focus on the issue of children’s access to oral health care.

The meeting participants also addressed the need for more fundamental reforms regarding the prevailing paradigm for treating oral disease and workforce development:

- ***Manage oral disease as a chronic disease.*** Some oral health experts are beginning to challenge traditional dentistry’s focus on treating the end-stage of oral disease – filling cavities or extracting diseased teeth – and propose that a model that emphasizes managing the disease itself is more appropriate. A disease management approach would identify those at highest risk for dental disease, target them for intensive prevention, education, and anti-microbial measures, and involve rigorous follow-up and management of their dental disease. The concentration of dental disease in certain subpopulations, including low-income children, and the progressive and cumulative nature of oral disease, highlight the potential benefit of targeting and practicing oral health care in this way.
- ***Develop an adequate oral health workforce.*** Overall inadequacies in the supply and distribution of the oral health workforce are compounded in Medicaid and SCHIP by low participation among dentists and the disproportionate burden of oral disease in the low-income population. These problems are national in scale and, ultimately, require coordinated policy at the federal level. A broad array of strategies, involving training, education, incentives, development of new dental providers, and other approaches hold potential to expand the productivity of our existing workforce and to help build a delivery system with greater capacity to meet and manage oral health care needs.

Introduction

In 2000, the first-ever Surgeon General's Report on Oral Health was issued. The report brought national attention to the importance of oral health as an integral component of general health, and to sharp income-related and other disparities in the burden of dental disease, despite great gains over the last 50 years in improving oral health in the nation overall. Among other findings, the report highlighted that poor children suffer twice as much dental caries (cavities) as other children and are more likely to go untreated.¹ Children experience pain and suffering as a result of untreated dental disease; in addition, they miss school and bear other important social costs. Though it happens rarely, inadequate access to oral health care can also lead to death in children. Two young children in Maryland and Mississippi died last year due to complications arising from untreated tooth decay.²

In 2007, over 29 million children – more than one-quarter of children in the U.S. – were covered by Medicaid, the nation's major safety-net health insurance program for low-income people; the State Children's Health Insurance Program (SCHIP) covered 7 million additional low-income children.³ Inadequate access to dental care in Medicaid has been widely documented. Dentists' low participation in the program is a fundamental cause; long travel times to see a dentist and poverty-related difficulties present additional obstacles and depress the demand for dental care. Notably, some states, using an array of legislative and programmatic strategies, have achieved substantial improvements in access to dental care for children enrolled in Medicaid and SCHIP.

Given the primary role of Medicaid and SCHIP in covering children, a logical and promising approach to increasing children's access to oral health care is to make targeted improvements in these programs. Recently, Congress followed this course by including in the Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA) – ultimately vetoed by President Bush – provisions that would mandate dental benefits and provide for increased monitoring of dental care access, use, and quality among children enrolled in Medicaid and SCHIP. Although the proposed new federal requirements died with the veto, they demonstrated broad consensus that Medicaid and SCHIP are essential vehicles for meeting the oral health care needs of

¹ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

² Mary Otto, "For Want of a Dentist," *Washington Post*, February 28, 2007, p. B01. Statement of Congressman John Dingell, House Committee on Energy and Commerce, March 27, 2007. http://energycommerce.house.gov/Press_110/110st29.shtml.

³ *Fact Sheet for CBO's March 2008 Baseline: Medicaid*, and *Fact Sheet for CBO's March 2008 Baseline: State Children's Health Insurance Program*. Congressional Budget Office, March 2008.

children – a viewpoint also reflected in the initiatives many states have adopted to improve children’s dental care in their programs.

In October 2007, the Kaiser Commission on Medicaid and the Uninsured and the National Academy for State Health Policy convened a meeting of diverse experts, including state and federal policy officials and program administrators, dental professionals, and others, to discuss children’s access to dental care in Medicaid and SCHIP, and to exchange information and assessments about what has worked best to improve it. In the day-long discussion that took place, the participants highlighted a wide assortment of actions that states can take in their Medicaid and SCHIP programs to strengthen low-income children’s access to dental care. In addition, they brought attention to fundamental systemic barriers to access and care that must ultimately be tackled, and considered how Medicaid and SCHIP programs might contribute.

Drawing on the experts’ discussion, the report that follows outlines the variety of practical approaches and measures available at the state level to improve children’s access to dental care in Medicaid and SCHIP. In many cases, state-specific examples are provided as illustrations. We hope that this “how-to” format is constructive to ongoing efforts across the country to ensure better access to dental care for our nation’s low-income children.

Framing the problem

Dental caries, or tooth decay, is the single most common chronic disease of childhood, affecting nearly 6 in 10 children in the United States – five times as many children as asthma.⁴ About 25% of all children have untreated caries in their permanent teeth.⁵ The consequences of poor oral health in children include pain that can interfere with school attendance, learning, and play, as well as impaired ability to eat and speak and diminished self-esteem. Poor oral health often continues into adulthood, and research shows linkages between poor oral health and heart and lung disease, diabetes, stroke, pre-term low birth weight.⁶ Health problems and functional limitations associated with oral diseases adversely affect economic productivity and quality of life as well. As prevalent as dental and oral disease are, and as serious as the health and social impacts can be, dental care is the most-often-reported unmet health care need among U.S. children.

Poor children suffer the most dental disease and are less likely to receive dental care. The burden of dental disease and conditions is not distributed evenly in children. The Surgeon General's report documented that poor children suffer far more, and more extensive and severe, dental disease than other children; indeed, they are about twice as likely to have untreated caries.⁷ Another federal report, by the U.S. General Accountability Office, indicates that 80% of untreated caries in permanent teeth are found in roughly 25% of children who are 5 to 17 years old – mostly from low-income and other vulnerable groups. That report also estimates that poor children suffer nearly 12 times more restricted-activity days, such as missing school, as a result of dental problems, than higher-income children.⁸ Because poverty is more prevalent among minority children than among whites, income-related disparities in oral health status can translate also into racial/ethnic disparities.

At the same time that poor children have more dental disease than other children, they are less likely to receive dental care.^{9 10} In 2006, nearly a quarter of all children age 2-17 had not had a

⁴ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

⁵ U.S. General Accountability Office, *Dental Disease is a Chronic Problem Among Low-Income Populations* (Washington, D.C.: GAO, 2000), GAO/HEHS-00-72.

⁶ *Oral Health in America*.

⁷ *Ibid.*

⁸ *Dental Disease is a Chronic Problem Among Low-Income Populations*.

⁹ U.S. General Accountability Office, *Factors Contributing to Low Use of Dental Services by Low-Income Populations* (Washington, D.C.: GAO, 2000), GAO/HEHS-00-149.

dental visit in the past year, but poor and low-income children were more likely to lack a recent visit than higher-income children (31% and 33% versus 18%).¹¹

A quarter of U.S. children depend on Medicaid and SCHIP. Nearly 30 million children – more than one-quarter of all children and 60% of poor children – receive health coverage through Medicaid, the nation’s major publicly funded safety-net health insurance program. An additional 7 million low-income children are covered by the State Children’s Health Insurance Program (SCHIP).

Under the mandatory Medicaid benefit known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), federal law requires states to cover comprehensive preventive care, diagnostic services, and treatment for children up to age 21. The EPSDT requirements encompass both coverage and arranging for care. The benefits required under EPSDT include preventive dental care, as well as all dental care that is medically necessary to restore teeth and maintain dental health (including orthodontics), as well as assistance in arranging for covered services, including scheduling and transportation. The Deficit Reduction Act of 2005 gave states increased flexibility with regard to how all the services required by EPSDT are provided, but the law expressly preserved the EPSDT coverage requirements, as well as the requirements related to arranging for care.

In SCHIP programs that are Medicaid expansions, the EPSDT mandate applies. However, in separate (non-Medicaid) SCHIP programs, dental benefits are optional and there is no requirement that states cover all medically necessary care. Consequently, dental benefits in states with separate SCHIP programs vary by state and may change over time. Currently, 14 states with separate SCHIP programs offer children the same benefits Medicaid provides; other states provide more limited benefits modeled after private insurance, with seven capping annual dental expenditures or limiting the number of dental services allowed per year. Today, all states except Tennessee cover some dental services under SCHIP.

Children in Medicaid and SCHIP lack adequate access to dental care. Despite EPSDT’s comprehensive coverage of dental care for children with Medicaid and dental coverage of some scope in nearly all SCHIP programs, children’s utilization of dental services remains far below

¹⁰ Edelstein BL, “Dental Care Considerations for Young Children,” *Spec Care Dentist* 22(3 Suppl): 11S-25S, 2002.

¹¹ Bloom B and Cohen RA. *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006*. National Center for Health Statistics. Vital Health Stat 10(234). 2007.

appropriate levels, pointing to important gaps in access. Different data sources vary, but tell a largely common story. Recent estimates of the proportion of children with public coverage who had no dental visit in the last year range from over one-quarter (National Health Interview Survey, 2006) to roughly two-thirds (Medical Expenditure Panel Survey, 2004 and CMS Form-416, fiscal year 2006).¹² Both limited access to dentists and poverty-related barriers to care underlie the disappointing statistics on children's use of dental care in Medicaid and SCHIP.

Few dentists participate in Medicaid. A core cause of inadequate access to dental care for children in Medicaid is dentists' limited participation in the program. In a 1999 survey of Medicaid directors in the 50 states and the District of Columbia, conducted by the General Accountability Office, 23 of the 39 states responding indicated that fewer than half the dentists in their state saw at least one Medicaid patient during that year. Only five states (of 31 responding) reported that 25% or more of their dentists treated at least 100 Medicaid patients, a figure approximating 10% of the patients a typical dentist sees in a year.¹³ A 2000 survey of Medicaid agencies conducted by the National Conference of State Legislatures also found low Medicaid participation. In 25 of the 42 states providing data on this question, fewer than half of all active private dentists received any Medicaid payment during the last year.¹⁴ And many dentists who are listed as Medicaid providers participate to a very limited degree. Data from the survey just mentioned show that, in five states, the share of active private dentists who billed Medicaid more than \$10,000 (equating to more than 23 children, or about two per month) was under 10%. In most of the states – 24 – the share of active private dentists with Medicaid billings at this level ranged between 10% and 25%. Less information is available regarding SCHIP participation.

Dentists consistently cite Medicaid's low payment rates as their chief reason for not accepting more Medicaid patients. Medicaid payment rates are typically much lower than other payers' rates, and often do not cover dentists' costs of providing care. Dentists also cite the Medicaid program's complex and nonstandard forms and burdensome administrative requirements. These deterrents to participation sharply exacerbate in Medicaid the current system-wide pressures on dental access that stem, in part, from a limited supply of pediatric dentists, in particular. In 2000, there were roughly 124,000 general practitioners in private practice nationally, but only 3,700

¹² Ibid. Also, Manski R J and Brown E., *Dental Use, Expenses, Dental Coverage, and Changes, 1996 and 2004* (Rockville, MD: Agency for Healthcare Research and Quality; 2007), MEPS Chartbook No.17. See http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb17/cb17.pdf. For CMS Form-416 data, see http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage.

¹³ *Factors Contributing to Low Use of Dental Services by Low-Income Populations.*

¹⁴ Gehshan S, Hauck P, and Scales J, *Increasing Dentists' Participation in Medicaid and SCHIP*, National Conference of State Legislatures, 2001.

pediatric dentists.¹⁵ While a recent workforce report from the American Dental Association maintains that there is not a shortage of dentists, it recognizes there are “geographic imbalances” that can affect access to care.¹⁶

Low-income families face extra barriers to seeking care. Even if they can find a dentist willing to accept public insurance, and even if the services are free or low-cost, low-income families often face additional barriers to access related to their economic and social disadvantage. Many low-income parents have difficulty securing time off from work to take their children to get care. They may also have to travel long distances for dental services – for example, 38% of rural counties have no dentist – which can be costly to families in terms of both time and money, or impede them from obtaining care altogether if they lack transportation. Trouble arranging child care for other children may stand in the way of access as well.

Finally, limited public awareness of the importance of oral health as a component of general health is a critical factor in the access and utilization equation in the population overall, contributing to inadequate demand for dental care. Indeed, the *National Call to Action to Promote Oral Health*, a public-private partnership under the leadership of the Office of the Surgeon General, named changing perceptions of oral health – increasing oral health “literacy” – as the first of the five steps in its action plan.¹⁷ Health literacy is lower in the low-income population and may be compounded by language and cultural barriers to care-seeking.

¹⁵ Brown LJ. *Adequacy of Current and Future Dental Workforce: Theory and Analysis*. Chicago: American Dental Association, Health Policy Resources Center, 2005.

¹⁶ Ibid.

¹⁷ U.S. Department of Health and Human Services. *National Call to Action to Promote Oral Health*. (Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research), NIH Publication No. 03-5303, Spring 2003.

Framing the solutions

Because of the major role of Medicaid and SCHIP in covering children, and the concentration of oral disease and unmet dental needs in the low-income children these public programs serve, substantial improvements in children’s oral health care overall require increased access and care for children enrolled in Medicaid and SCHIP.

Leadership fosters action. In a policy environment crowded with priorities, and as a small component of states’ overall Medicaid and SCHIP budgets, dental care faces tough competition for policymakers’ focus and commitment. For that reason, the cultivation of leadership on this issue in the legislative and administrative branches of state government is critical. Dental “champions” and active dental care coalitions can be key to increasing public engagement, winning dental care in Medicaid and SCHIP a place on the agenda, and strengthening political will. Broad coalitions that include a wide range of stakeholders – for example, provider associations, health centers, child advocates, schools, advocates for the poor, etc. – indicate to legislators and other policy officials a high level of interest in improving access to dental care and provide important support for positive action.

States have many levers to improve dental access in Medicaid and SCHIP. Extensive programmatic flexibility within Medicaid and SCHIP, interagency partnerships and coordination, and state-level legislative initiatives offer the states important levers for responding to the dental access challenges they confront. States can use these mechanisms to:

- promote provider participation;
- expand the supply of dental care;
- improve dental benefits;
- increase oral health education and patient support; and
- improve data collection, monitoring, and evaluation.

Larger systems reforms are also needed. Some states have made remarkable progress in improving access to dental care in Medicaid and SCHIP using the policy and programmatic mechanisms available to them. And, through the combined force of Medicaid, SCHIP, state-funded health programs, and public employee dental benefits, most states have considerable potential clout in the realm of oral health care. Nevertheless, states alone cannot reform clinical practice to reflect the emerging perspective that chronic disease management, not acute care, is the proper model for organizing and delivering oral health care. Some states have used the levers

they have – for example, periodicity schedules and decisions to permit a broader array of provider types and/or settings to receive payment for key dental services – to push oral health care in this direction. But states can only go so far in the absence of more system-wide reforms in the practice of oral health care. Similarly, even if the states took every step possible to improve access to dental care in Medicaid and SCHIP, they could not remedy systemic, underlying inadequacies in the supply and distribution of the oral health care workforce in the U.S.

Ultimately, these care delivery and workforce challenges require concerted policy action beyond the purview of Medicaid and SCHIP. In the meantime, however, aligning Medicaid and SCHIP program design and financing with broader system goals could lead to improved care for the millions of children enrolled in these programs and help to achieve progress for the nation as a whole.

I. State Levers to Improve Children’s Access to Dental Care

Promote increased provider participation

A key challenge facing Medicaid and SCHIP programs is achieving and maintaining an adequate level of program participation among dental providers. Meeting this challenge is essential if low-income children are to have access to appropriate oral health care. Medicaid and SCHIP payment rates typically fail to cover dentists’ overhead costs, and most dentists easily develop a full roster of privately insured patients and/or patients who can pay for services out-of-pocket.

Unnecessarily burdensome administrative hassles associated with Medicaid have also deterred participation. Although most dentists donate at least some services, their charity care does not constitute a coordinated or reliable system of care for the low-income children in Medicaid and SCHIP. To develop robust Medicaid and SCHIP dental programs, states must take steps to increase and support providers’ participation in the programs.

- **Increase Medicaid payment rates.** Anecdotally and in most surveys, Medicaid’s low payment rates are the reason dentists cite most often for not participating, or participating only minimally, in the program. Originally, state payment amounts were based on dentists’ usual and customary fees, but rate increases in Medicaid and SCHIP must generally be authorized by state legislatures, which can go years without raising rates meaningfully, especially when budget pressures are difficult.

Dental practices are small businesses, and overhead costs for dentists exceed those for most physicians, averaging 60 cents of every dollar earned.¹⁸ The dental equipment needed to set up an office is expensive, and dentists must also hire staff, lease or purchase space, carry insurance, provide parking, file claims, and administer payroll. Further, most dental students graduate with educational debt.

Federal Medicaid law requires states to “assure that payments are...sufficient to enlist enough providers so that care and services are available under the [Medicaid] plan at least to the extent that such care and services are available to the general population in the geographic area...”.¹⁹ This federal standard has generally not been enforced. However, several states

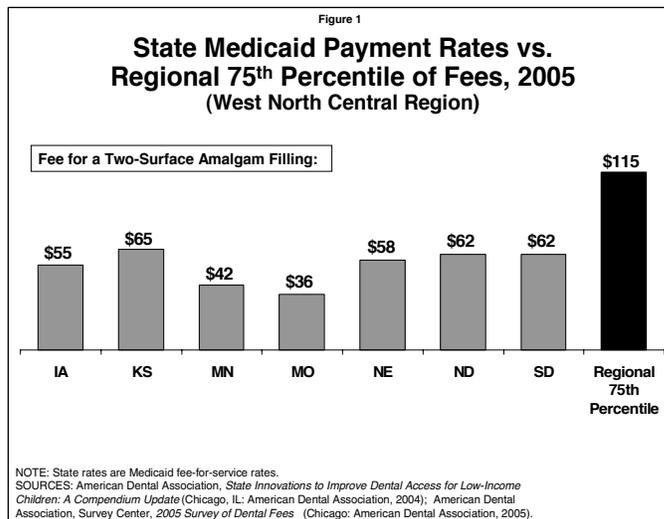
¹⁸ Gehshan S and Wyatt M. *Improving Oral Health Care for Young Children*. Portland, ME: National Academy for State Health Policy, 2007.

¹⁹ Section 1902(a)(30)(A) of the Social Security Act.

have raised Medicaid payment levels to retain or increase dentists' participation – sometimes in response to legal action on the part of children's advocates based on failure to comply with the federal standard.²⁰

Two “benchmarks” suggest the payment levels that may be necessary to achieve these objectives. The *breakeven* price is the payment level that covers the cost of providing a service. The *marketplace*

price for a service, a concept articulated by the American Dental Association (ADA), is the amount equal to (or exceeding) the fee charged for the service by 75% of dentists in a geographic area. The ADA suggests that this market-based



approach to setting Medicaid payment rates would narrow the gap between Medicaid rates and the rates typical in the commercial insurance sector, and generate increased provider interest in participating in Medicaid (Figure 1).²¹

Moving forward...

- As part of **Tennessee's** comprehensive reform of its TennCare dental program in 2002, dental payment rates were raised to the 75th percentile of the fees published in a 1999 American Dental Association (ADA) Survey of Fees for the region.
- In 1998, **South Carolina** instituted a provision rate increase, conditioned on an improvement in provider participation. When the Medicaid agency, working closely with the state dental association, exceeded its provider enrollment target, the state raised payment rates to the 75th percentile of private-sector fees in the state.²²

Continued...

²⁰ National Health Law Program, Docket of Medicaid Cases to Improve Dental Access. Accessed at: <http://www.healthlaw.org/library/item.157322>.

²¹ American Dental Association. *Medicaid Reimbursement for Mid-Atlantic Region – Using Marketplace Principles to Increase Access to Dental Services* (Chicago, IL: American Dental Association, 2004).

²² Borchgrevink A, Snyder A, and Gehshan S, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care* (Washington, D.C.: National Academy for State Health Policy, 2008).

Continued...

- Despite an extremely difficult budget environment, **Florida** Governor Charlie Crist included \$21.8 million in his proposed 2008 budget to increase Medicaid payment rates to dentists by an average of 20%.²³ Although the measure did not ultimately pass, its inclusion in the budget blueprint indicates the high priority the Governor attached to it.
- In April 2008, the **Maryland** legislature approved \$7 million in state funds (to be matched by \$7 million in federal funds) to raise Medicaid dental rates.²⁴

The experience in some states indicates that fee increases need not necessarily reach the 75th percentile standard to expand dentists' participation.²⁵ In restrictive state fiscal environments, more modest rate increases can be combined with other strategies to build goodwill with dental providers, payment increases can be reserved for dentists who accept a threshold volume of Medicaid patients, and increases can be targeted to improve the participation of needed dental specialists or the supply of specific services.

Moving forward...

- In 2002, **Minnesota** increased rates by 40% for "critical access dental providers." Critical access dental providers were defined, initially, as those with annual Medicaid revenue of \$10,000 or more. In 2007, the state changed the designation, to refer to those dental providers whose patient load is least 20% Medicaid enrollees.
- In 2005, the **Virginia** legislature approved a 28% rate increase for Medicaid and SCHIP dental services, to be followed by a 2% rate increase in 2006. The larger increase was distributed evenly across all dental services but, on the advice of the Dental Advisory Committee, the 2% increase was targeted to certain oral surgery and other services for which referrals were difficult to find. While a cause-and-effect relationship has not been ascertained, Virginia has seen the number of Medicaid providers increase from 620 to 1,007, and the proportion of children receiving care increase from 24% to 35%.²⁶

- **Establish dedicated funding for dental care.** When fiscal pressures drive state legislators to consider Medicaid budget-cutting options, lawmakers often freeze or cut Medicaid

²³ Governor Charlie Crist's Policy and Budget Recommendations, Fiscal Year 2008-2009. Accessed at: [http://www.thepeoplesbudget.state.fl.us/\(S\(rlrya55azz2oe45w3dkt5qv\)\)/Highlights/healthcare/healthcare_home.aspx](http://www.thepeoplesbudget.state.fl.us/(S(rlrya55azz2oe45w3dkt5qv))/Highlights/healthcare/healthcare_home.aspx).

²⁴ Mary Otto, "Dental-Care Access Expands," *Washington Post*, April 20, 2008, p. SM02.

²⁵ Borchgrevink et al.

²⁶ Presentation by Virginia Department of Medical Services on *Smiles for Children* program, for Virginia Rural Health Association Annual Conference, November, 2007. Accessed at: <http://www.vrha.org/Conference/07Conference/Presentations/SmilesForChildren.pdf>.

provider rates in order to avoid eligibility reductions and other difficult policy choices. One course state legislators can take to protect Medicaid payment rates from budget-cutting pressures is to seek broader or dedicated funding to help finance dental care under the program. Possible legislative approaches range widely, from establishing “play or pay” systems that require providers who do not participate in public programs to pay an assessment that helps finance the programs, to levying a consumption tax on sugary drinks, for example. Some have suggested legislation that would bar freezes or cuts in Medicaid payment rates for dental care, or that would trigger periodic or automatic increases in these rates (e.g., based on inflation).

Moving forward...

- The **Wisconsin** Dental Association has proposed a fee on sugared beverages, called “Two Cents for Tooth Sense.” Because of the high consumption of these beverages, the proposed 2-cent surcharge on each 12 ounces of soda could generate an estimated \$70 million.²⁷

- **Ease administrative burdens.** Second only to inadequate payment levels, dentists’ chief complaint about Medicaid is the administrative burden associated with participating in the program. Complicated Medicaid claim forms that differ from the forms dentists use for their privately insured patients are onerous and costly for dental offices to handle, especially if the dentist sees few Medicaid patients. Dentists also cite frustration about their inability to obtain real-time information on their patients’ Medicaid eligibility status. In addition, some dentists report that the pre-authorization requirements some state Medicaid programs impose are arbitrary, time-consuming, and a burdensome infringement on dentists’ professional judgment.²⁸

States that have successfully increased dentists’ participation have maximized the extent to which their Medicaid requirements, claim forms, and processes mirror those of commercial insurance. In short, it appears that the more the experience of participating in Medicaid resembles participating in private insurance, the better. Online and toll-free, automated voice response systems for verifying Medicaid eligibility have also improved the participation

²⁷ See the Wisconsin Dental Association proposal at: <http://www.wda.org/categories/13-consumer-awareness/subcategories/125-access-to-dental-care/documents/89-medicaid-two-cents-for-tooth-sense>.

²⁸ See, for example:

http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_008302.pdf.

experience for dentists. With regard to complaints about Medicaid pre-authorization requirements, many states have examined or altered such requirements and some states are considering alternative program integrity mechanisms such as post-payment review and closer monitoring of utilization.

With sufficient financing and sustained management efforts on the part of the state, any service delivery system can be responsive to the needs of dental providers. States can make administrative improvements in fee-for-service programs that they administer themselves, as Alabama has, and they can also increase the attention given to monitoring dental provisions of contracts with the managed care organizations (MCO) that deliver benefits to Medicaid enrollees. As of 2004, 18 states provided dental benefits to some portion of their Medicaid enrollees through combined medical and dental managed care contracts.²⁹ However, a third option, often promoted by state dental associations, is for the state to purchase specialized expertise in dental administration by contracting out provider relations and administrative functions to a dental benefits vendor, and “carving out” dental from other service delivery systems. Choosing a single administrator can reduce providers’ frustration by replacing multiple MCOs, each with its own administrative requirements, with a single set of rules and contacts. This arrangement can also yield the additional benefit of centralizing dental claims data, which the state can use to support a variety of program needs.

Moving forward...

- **Tennessee, Virginia, Massachusetts**, and other states contract with a dental benefits manager (DBM) for administrative services only; the DBM is not at financial risk for higher-than-anticipated utilization. In each of these states, Doral Dental manages claims processing, pre-authorization, provider outreach and support.
- In **Michigan’s** Healthy Kids Dental program, Medicaid covered children are enrolled in a plan administered by Delta Dental of Michigan that utilizes Delta’s provider network and closely resembles its commercial plan. Since its inception in 2000, utilization of dental services has increased steadily, and the distance children in Medicaid must travel for care is now comparable to the distance privately insured children face.

- **Provider outreach.** Personalized outreach to dentists is an important mechanism for drawing providers into Medicaid. Some states have invested substantially in efforts aimed at orienting dental offices to the program and enrolling them. These efforts include contacting

²⁹ *Medicaid Program Administration*. Chicago: American Dental Association, March 2004. Available at: http://www.ada.org/prof/advocacy/issues/medicaid_administration.pdf.

all dental providers in the state, arranging one-on-one visits to dental offices by dental outreach specialists who provide information and assistance, and conducting provider-focused workshops on Medicaid issues.

Moving forward...

- The Medicaid programs in **Virginia** and **Michigan** have experienced success using a “dental ambassador” from the dental association as a mentor for providers. They report that dentists are often more receptive to messages about program improvements that come from their dental colleagues.

- **Increase support and assistance to providers.** States have taken a variety of steps to increase support and service to dentists to promote their participation in Medicaid. A few states have implemented more integrated strategies that approach the participation challenge from several directions simultaneously.

Moving forward...

In 2000, when Alabama established the Smile Alabama! program, the state adopted a multi-pronged strategy to reach out to dentists and support their participation in Medicaid:

- The state set Medicaid payment rates for dentists at 100% of Blue Cross/Blue Shield’s dental fees.
- State officials made in-person visits to dental offices to explain the improvements the state had made, provide informational kits and gifts such as “Smile Alabama!” mugs, and ask the dentists to enroll as providers.
- To simplify and streamline claims processing, Alabama set up a toll-free number for providers who have questions or need information about payment. The state also simplified the dental provider manual and provided software that not only enables dentists to submit claims electronically, but also notifies the dentist if something is submitted incorrectly.
- Alabama Medicaid staff have the ability to access claims online and troubleshoot claims-related problems in real-time. Also, the state has made it possible for dental offices to verify their patients’ Medicaid eligibility status instantly online.
- The state provided dental office managers with a “cheat sheet,” a one-page document that identified for claims processing staff the most common claims problems and guided them on how to avoid denials of payment. This kind of support addresses two important deterrents to dentists’ participation in Medicaid -- payment-related hassles and slow payment. Claims processing time following introduction of the cheat sheet was as little as two days and no more than two weeks.

Expand the supply of dental care

Growing concern about shortages in the supply of dentists and dental specialists, and misdistribution of the existing supply, are national problems that require a coordinated policy and planning response at the national level; solving these problems is also a long-term enterprise. In the more immediate term, although their ability to affect the supply of *dentists* is limited, states can and do use various strategies to enlarge the available supply of *dental care* for children in Medicaid and SCHIP.

Some states have adopted initiatives that provide for training general dentists to care for children. Some states use technology to link general dentists with specialists who can provide consultations, and to enable dentists to supervise allied dental personnel practicing in other locations. Paying pediatricians for providing oral health education and certain dental services to children in Medicaid and SCHIP has also increased children's access to dental care, as pediatricians are more likely than dentists to participate in these programs, and they see children frequently during the first few years of life.

States can also use their licensing authority to enlarge the supply of dental providers. For example, states have sought to loosen restrictions on existing dental providers, such as dental hygienists, and to broaden the types of oral health activities physicians can perform. Some states have explored licensing new provider types to furnish certain services, or to furnish care in certain settings. In addition, states can increase access by leveraging Medicaid and SCHIP service and administrative dollars to provide a sound source of financing to programs that play a major role in serving low-income children. As one example, Medicaid and SCHIP can provide substantial financing for school-based sealant programs – commonly staffed by dental hygienists – in low-income areas where many children in Medicaid and SCHIP can be served.

Moving forward...

- To help cope with the scarcity of pediatric dentists participating in Medicaid, **Washington State's** Access to Baby and Child Dentistry (ABCD) trains general dentists in how to deliver care to children under age 5 – who are ideally seen by pediatric dentists. In return for participating in this training (which is not typically part of generalists' dental education), general dentists receive enhanced Medicaid fees for services provided to these children.³⁰

Continued...

³⁰ Nagahama SI, Fuhriman SE, Moore CS, Milgrom P, "Evaluation of a Dental Society-Based ABCD Program in Washington State," *Journal of the American Dental Association* 133 (September 2002).

...Continued

- **California** uses technology to extend the reach of specialists into rural and frontier areas. Clinics in these underserved areas are connected electronically to pediatric dentists and other specialists who can advise on complex cases. This set-up enables general dentists to care for patients they would not otherwise feel comfortable treating and improves the care they deliver. A similar high-speed network linking schools, clinics, and hospitals permits dentists to provide general supervision to dental hygienists delivering preventive services to children in underserved rural areas.³¹

California is also pioneering the use of Registered Dental Hygienists in Alternative Practice (RDHAP). RDHAPs can practice in a wide variety of community-based settings, including health centers and clinics, schools and other institutions, and homes. They are licensed to provide hygiene services prescribed by a dentist, physician, or surgeon who has examined the patient. RDHAPs refer patients to dentists for restorative and advanced procedures, but can greatly expand access by going directly to patients who are unable to travel to a dental office or clinic.

- In **Alaska**, the Indian Health Service uses specialized computer carts developed by the Alaska Federal Health Care Access Network that allow dental therapists in remote villages to send digital x-rays and images through a wireless network to supervising dentists, who may be stationed hundreds of miles away.³²
- **North Carolina's** "Into the Mouths of Babes" project pioneered the approach of training physicians, nurse practitioners, and nurses to provide preventive oral health services and anticipatory guidance. These medical – not dental – providers can receive Medicaid payment when they provide a set of services that include a visual screening for decay, education of patients and parents about proper hygiene and care-seeking behavior, application of fluoride varnish, and referral of patients in need of a dentist's care.
- Currently, 12 states – **California, Colorado, Connecticut, Maine, Minnesota, Missouri, Montana, New Mexico, Nevada, Oregon, Washington, and Wisconsin** – pay dental hygienists directly for services under the Medicaid program.³³

Improve dental benefits

In focus groups and other studies, dental care for children emerges as one of the benefits of Medicaid and SCHIP that parents value most, and in parental assessments of unmet health needs among children in SCHIP, dental care exceeds all other unmet needs combined. These findings argue for the importance of robust dental benefits for children in Medicaid and SCHIP.

³¹ Plotkin D, "Ehealth Program: Teledentistry." Retrieved December 7, 2007, at: <http://connect.csba.org/swc/documents/Oral%20Health%20An%20Emerging%20Children's%20Health%20Issue.pdf>.

³² www.afhcan.org.

³³ American Dental Hygienists' Association. See: http://www.adha.org/governmental_affairs/downloads/medicaid.pdf.

- **Fully implement EPSDT.** Conceptually, EPSDT is a model of comprehensive and integrated care for children, emphasizing preventive and primary care as well as treatment. EPSDT requires states to provide children with all services that are determined to be medically necessary, and this standard applies to dental as well as other health care. Under EPSDT, preventive dental care, including oral health education, must be provided at regular intervals that meet the reasonable standards set by each state in consultation with state and local dental organizations. Further, children must receive direct dental visits; an oral health exam or screening as part of a general physical examination is not sufficient. At a minimum, children must receive services that provide relief of pain and infections, restoration of teeth, and maintenance of dental health.

While the EPSDT benefit establishes a legal entitlement to comprehensive health care for low-income children enrolled in Medicaid, persistent gaps in the implementation and enforcement of EPSDT leave needed services out of the reach of many children. States can do more to ensure that children receive the full scope of dental care that EPSDT guarantees to them.

- **Periodicity schedule for dental care.** Although required by federal law, many states have not adopted EPSDT periodicity schedules for dental care in consultation with their state dental association or dental advisory group. The American Academy for Pediatric Dentistry has pointed out that an appropriate periodicity schedule benefits children by promoting a ‘dental home’ and prevention of oral disease, resulting in improved oral health care for our nation’s most vulnerable children.”³⁴ A well-defined set of clinical guidelines that is vigorously enforced by federal Medicaid authorities would give state policymakers and program managers a powerful tool to make the programmatic changes necessary to improve dental access.
- **Enabling services.** Many low-income families need assistance with scheduling dental appointments for their children and arranging transportation and child-care. Working parents in these families may not have the considerable time or resources necessary to identify a dentist willing to see their children; further, even if they can locate one, long travel distances, transportation needs, and/or child-care needs for other children may prevent them from

³⁴ American Academy for Pediatric Dentistry, *The AAPD’s Medicaid EPSDT Dental Periodicity Schedule Initiative*, Presentation for the AAPD Advocacy Forum, May 2007. Retrieved May 12, 2008 at www.aapd.org.

actually obtaining care for their children. Supports such as easy access to a current directory of participating dentists and scheduled appointment reminders, as well as coordination of transportation for enrollees, are often needed to bridge critical gaps in low-income children's access to dental care.

Moving forward...

- **Rhode Island** helped Medicaid enrollees overcome obstacles to dental care access by requiring its dental managed care organization to conduct outreach to enrollees as well as providers. RIte Smiles, the state's dental program for children in Medicaid, provides support for families who have had trouble keeping appointments, and also visits providers on-site to provide one-on-one assistance.
- **California** dedicates time from staff in the state's social service agencies to coordinate dental services for individuals with special needs. Data (unpublished) indicate that, two years after this care coordination activity was piloted, Medicaid dental costs for each patient fell by \$240 per year. Based on these results, the state legislature included a provision in the California budget for a staff position in social services agencies statewide to perform this coordination function.

- **Stronger MCO contracts.** In state Medicaid programs that contract with managed care organizations to provide dental benefits to children, contract language that clearly defines a pediatric standard of medical necessity, the MCO's benefit obligations under EPSDT, and the data the plan must provide, improves states' ability to monitor plan performance and ensure effective implementation of EPSDT.
- **Broaden SCHIP dental benefits.** In some states whose SCHIP benefits are modeled on private insurance, dental benefits are limited and cost-sharing is required. Broad coverage of preventive and primary dental care as well as treatment, and elimination of cost barriers, improve the likelihood that low-income children will obtain appropriate dental care and that preventable dental disease – costly in health, social, and financial terms, alike – can be avoided. In addition to comprehensive dental services per se, the care-seeking supports and coordination included in EPSDT can be expected to assist low-income children enrolled in SCHIP as well as Medicaid.

Increase oral health education and patient support

Limited awareness of the importance of oral health is a large public health issue, relevant to but not limited to the low-income population. The many spheres of state activity and streams of state funding position states to play an important role – both in Medicaid and SCHIP and through other

programs – in educating the public about oral health. Coordinated outreach and education efforts can capitalize on the participation by many low-income families in multiple programs. Head Start, health centers, local health departments, and other maternal and child health organizations are all platforms for outreach to low-income families, education about oral health, and early identification of children who need help gaining access to dental care. Indeed, Head Start and Early Head Start program standards explicitly refer to establishment of a dental home for children at an early age.³⁵

Moving forward...

- In **Alabama**, public service announcements about the importance of dental care were geared to the whole population, reaching Medicaid enrollees without narrowly targeting them. The state also placed videos in primary care providers' offices conveying the importance of beginning oral health care at a young age.
- In **South Carolina**, the Supplemental Nutrition Assistance Program for Women, Infants and Children uses the age 1 health certification visit to distribute information about the importance of a dental health check.
- The multi-state *Watch Your Mouth* campaign is making children's oral health a priority in **Maine, Massachusetts, and New Hampshire**.³⁶ The campaign educates the public about the prevalence of tooth decay, the connection between oral disease and diminished school performance, and the relationship between oral and overall health.

Separate from outreach and education efforts, states can structure their Medicaid and SCHIP programs in ways that improve and more effectively support low-income families' use of recommended dental care for their children. States can structure such supports through Medicaid and SCHIP benefits, administration, and dental care delivery systems. To illustrate, "patient navigators," care coordinators, case managers, and disease management programs in various states help enrollees connect with dentists, remove access barriers for them, and help them obtain the services they need.

³⁵ Schneider D, Rosetti J, and Crall J. *Assuring Comprehensive Dental Services in Medicaid and Head Start Programs: Planning and Implementation Considerations*. Los Angeles, CA: National Oral Health Policy Center, 2007.

³⁶ www.watchyourmouth.org.

Moving forward...

- Under a recently passed **Minnesota** law, Medicaid payment can be made for care coordination and patient education provided by qualified community health workers (CHW) who are under the supervision of specified types of providers, including dentists. The care coordination and patient education services covered under this law specifically include “services related to oral health and dental care.”

Some states have found that managed care arrangements for delivering dental care improve access relative to fee-for-service. First and foremost, they establish networks of participating dental providers. In addition, the scope of dental plans’ or dental benefit administrators’ responsibilities can include providing enrollees with a directory of providers and other materials, and assisting them in choosing a provider. These entities can also be charged to problem-solve with enrollees who chronically miss appointments, addressing an important need of both enrollees and providers for increased support.

Moving forward...

- In **Pennsylvania**, under the state-administered fee-for-service system, the state has implemented the ACCESS Plus program in 42 counties by contracting with a vendor to provide primary care case management and disease management services. Under ACCESS Plus, the vendor conducts outreach annually to enrollees under the age of 21 to remind them to schedule an appointment with a dentist. When requested, the vendor also provides assistance in scheduling the appointment. Pennsylvania found that this service helped enrollees find a dental provider.
- **Virginia’s** dental benefits manager, Doral Dental, employs a case manager who follows up with families who miss appointments to let them know they are at risk of being dropped from the provider’s patient roster.

Improve data collection, monitoring, and evaluation

For policymakers to build the case for state action, they need to develop the capability to measure and monitor oral health access and need among low-income children. Similarly, to ensure wise investment of scarce public funds, they need data on both the consequences of inaction and the estimated impacts of interventions they may seek to replicate or adapt. State public health agencies are often charged, but inadequately funded, to collect surveillance data that can trigger

strategic programmatic investments. Such data can include measures like the prevalence of molar sealants among third-graders, untreated decay among elementary school children, and the oral health status of different racial and ethnic groups.³⁷ Evaluations that document the impact of new initiatives can help motivate improvement, guide future policy, and sustain focus on the access issue.

Moving forward...

- As part of the **Rhode Island** Health Indicator System, an Oral Health Module was developed to provide measures for the design, monitoring, and evaluation of the first dental managed care program for children in Medicaid (Rite Smiles). The Oral Health Indicators were used to develop baseline measures of unmet need and trended oral health outcomes for Rhode Island's Medicaid children.³⁸
- **Virginia's** experience is that having a single dental care administrator for children in the state's Medicaid program has the added benefit of centralizing data. Doral Dental analyzes data and assists the state with program evaluation and quality assurance.
- Researchers at the University of Michigan monitor **Michigan's** Healthy Kids Dental program, helping the state to track the program's progress toward its goals of improved access to dental care.³⁹

³⁷ See, for example, state data collected by The National Oral Health Surveillance System, posted at: <http://www.cdc.gov/nohss>, and data from Wisconsin's *Make Your Smile Count* survey, at: http://dhs.wisconsin.gov/health/Oral_Health/pdf_files/pph0001makeyoursmilecount.pdf.

³⁸ See: http://www.ritecare.ri.gov/documents/reports_publications/Baseline_Oral_Health_Indicators.pdf.

³⁹ See, for example, Eklund S, Pittman J, and Clark S, "Michigan Medicaid's Healthy Kids Dental Program," *Journal of the American Dental Association* 134 (November 2003): 1509-1515.

II. Systemic Reforms to Improve Children’s Access to Dental Care

While states have substantial opportunities to improve children’s access to dental care in Medicaid and SCHIP, fundamental reforms beyond the domain of state policy alone will ultimately determine how much progress is achieved. These reforms relate primarily to:

- 1) rethinking the prevailing paradigm for treating oral disease, which emphasizes acute care; and
- 2) developing an oral health care workforce that is adequate to meet the nation’s needs.

Manage oral disease as a chronic disease. Some oral health experts are beginning to challenge traditional dentistry’s focus on treating the end-stage of oral disease – that is, on filling cavities or extracting diseased teeth – and propose that managing the disease itself is the appropriate clinical approach. The bacterial infection that causes cavities is a chronic, progressive, transmissible disease. Although almost everyone is colonized by these bacteria as children, most people do not have active decay because various protective factors (e.g., fluoride intake, oral health habits) outweigh their risk factors (e.g., bacterial load, diet). However, when the risk factors prevail, this balance is broken, and the acids produced by the bacteria cause lesions on teeth which progress into cavities, and, sometimes, abscesses and destruction of tooth structure.⁴⁰ Drilling out and filling cavities addresses a major symptom of dental disease, but not the disease itself. This explains why low-income children with advanced decay have a high rate of recurrences not long after expensive treatment.⁴¹

A disease management approach, which has been pioneered in the care of recognized chronic diseases such as diabetes and asthma, would identify those who are at highest risk for dental disease, and target them for intensive prevention, education, and anti-microbial measures.⁴² It would also involve rigorous follow-up and management of their dental disease. The concentration of dental disease in certain subpopulations, including low-income children, and the progressive and cumulative nature of tooth decay and gum disease, highlight the potential benefit of targeting and practicing oral health care in this way. About 25% of children have untreated caries in their permanent teeth, but 80% of all untreated caries in permanent teeth are found in

⁴⁰ For more on the “caries balance” idea, see Featherstone J, “The Science and Practice of Caries Prevention,” *Journal of the American Dental Association* 131, no. 7 (2000): 887. <http://jada.ada.org/cgi/content/abstract/131/7/887>.

⁴¹ See, for example, Almeida AG et al., “Future Caries Susceptibility in Children with Early Childhood Caries Following Treatment Under General Anesthesia,” *Pediatric Dentistry* 22, no. 4 (Jul.-Aug. 2000): 302-306, and Foster T et al., “Recurrence of Early Childhood Caries After Comprehensive Treatment with General Anesthesia and Follow-Up,” *Journal of Dentistry for Children* 73, no. 1 (Jan.-Apr. 2006): 25-30.

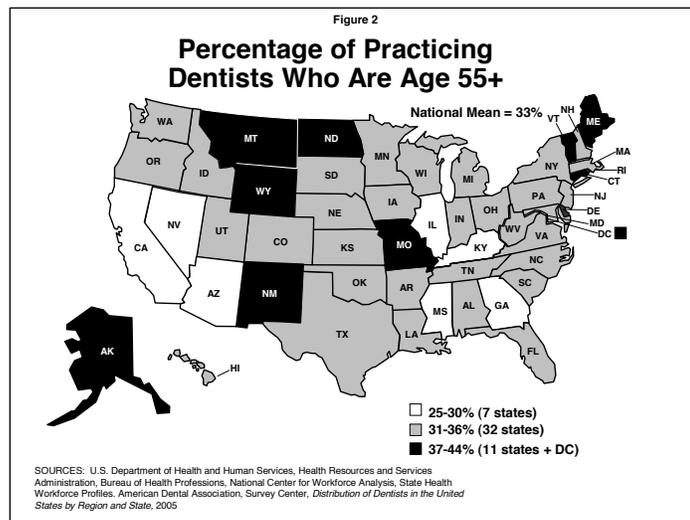
⁴² See *Principles on Preventing and Managing Pediatric Dental Caries*, Children’s Dental Health Project, May 2008.

about 25% of children age 5-17 – mostly from low-income and other vulnerable groups. Not surprisingly, low-income adults experience more untreated caries and greater tooth loss because of decay or gum disease than their higher-income counterparts.⁴³

While Medicaid and SCHIP alone cannot transform the practice of dentistry, states can use their discretion in many of the ways outlined earlier to align the programs’ payment incentives, benefit design, contract requirements, educational campaigns, and other aspects with that larger goal. The large role of Medicaid and SCHIP in providing coverage for children, combined with their significant purchasing clout, makes the programs a defining influence on the access and care that low-income children experience and, thus, a key instrument of efforts to improve oral health care.

Develop an adequate oral health workforce. The current delivery system – an uncoordinated network of private providers and a critical but limited safety net of clinics and schools – fails to serve about one-third of the American public.⁴⁴ All states have a geographic misdistribution of dentists that leaves multiple areas in their states with either too few or no dentists. Dental health professional shortage areas, designated by the federal DHHS, exist all over the country, not only in rural and frontier areas. According to the Bureau of Health Professions, about 10,000 dental providers are needed now to serve about 1,700 designated dental health professional shortage areas, both rural and urban, where more than 26 million underserved people live.⁴⁵

The education of dentists is not keeping pace with the need. Moreover, the largest cohorts of practicing dentists are approaching retirement (Figure 2). Finally, the dentist-to-population ratio is declining. These structural shortages are compounded in Medicaid and SCHIP by low participation rates among dentists and the disproportionate burden of oral disease in the low-income population.



⁴³ *Oral Health in America.*

⁴⁴ Bailit H et al., “Dental Safety Net: Current Capacity and Potential for Expansion,” *Journal of the American Dental Association*, 137, no. 6 (2006): 807-815.

⁴⁵ Health Professional Shortage Area (HPSA) Designated Dental Care HPSA Summary (as of July 10, 2008), HRSA Geospatial Data Warehouse. See: <http://datawarehouse.hrsa.gov>.

To the challenges already posed by inadequacies in the supply and distribution of the oral health workforce can be added a new challenge – to build systems of oral health care that support a disease management approach that more closely aligns service capacity and the content of care with disease burden. Strategies to tackle these large, structural issues deal with different pieces of the puzzle. While the problems are national in scale and, ultimately, require coordinated policy at the federal level, states have some levers for fostering improvements. Some states are exploring the development of new dental providers to whom dentists – who are highly trained scientists and surgeons – could delegate less complex procedures, thereby expanding their own productivity and increasing the capacity of the care delivery system.

New Dental Providers

Advanced Dental Hygiene Practitioner (ADHP): The American Dental Hygiene Association has proposed this new licensed mid-level provider. Currently, there is no mid-level provider in dentistry, equivalent to a nurse practitioner or physician assistant, who has education and scope of practice midway between a physician and a nurse. The ADHP is proposed as a two-year Master's-level degree that Registered Dental Hygienists (who typically earn a Bachelor's or Associate's degree) might be expected to pursue.

Community Dental Health Coordinator (CDHC): This provider model is proposed by the American Dental Association. The CDHC would be a dental assistant or community health worker with 12 to 18 months of training after high school and would be certified, rather than licensed. This provider would furnish only a few clinical services, under direct supervision, and would primarily provide health education in community settings and refer patients to dentists.

Dental therapists: Dental therapists are dental technicians who perform a limited range of preventive and restorative procedures. They are in use in 53 other countries (primarily in school settings), but have not been introduced in the United States, except by the Indian Health Service (IHS) in Alaska. Dental therapists receive two years of training after high school that are equivalent to the last two years of dental school in the United States. They work under the general supervision of a dentist and refer patients to dentists for more complex procedures. In Alaska, therapists are employed in IHS clinics in frontier areas that have difficulty attracting and supporting a dental practice.

Expanded Function Dental Assistants (EFDAs): Although these are not new providers, they are little used in most states. However, they show promise to expand the productivity of large private dental practices and safety net clinics, and enable care to be delivered to patients at a lower cost. EFDAs are dental assistants who receive extra training that equips them to perform components of procedures like applying sealants and filling cavities. When they are included in the process of dental care delivery, they save dentists' time and effort, which can be devoted to more complex dental care. The expanded scope of duties for EFDAs varies by state, and only a few states, such as Pennsylvania, California and Vermont, along with the IHS and the armed forces, use them extensively. Their limited use is due partly to the fact that dental schools generally do not train dentists to work with them.⁴⁶

⁴⁶ Gehshan and Wyatt.

Another kind of effort in the area of dental education involves enhancing dental students' exposure to and training in community-based settings, where they will see and care for a wide variety of patients and learn about access barriers first-hand. Not only do these programs provide safety-net settings (e.g., health centers, Rural Health Clinics, local public health department clinics, volunteer clinics) with students who can augment the volume of care they can provide, but they produce dentists who are more predisposed to care for low-income patients once they enter private practice.

A number of states now provide rotations for dental students in community-based clinics, and some dental schools are moving toward an optional post-graduation year of service that would expose new dentists to the experience of caring for populations that they might not otherwise encounter in private practice. Minnesota uses a different strategy to promote better access for underserved communities, earmarking some of its graduate medical education funds for dental school loan repayment for students to agree to work in practices that see large numbers of low-income and Medicaid patients. In yet another approach, the Arizona School of Dentistry and Oral Health seeks to attract a new type of student, whose volunteer experiences in high school and college demonstrate a commitment to community service. Fully one-third of the class graduating in 2006 chose to enter a public health setting, rather than a private practice.⁴⁷

⁴⁷ Personal communication with Dean Dr. Jack Dillenberg, December, 2007.

Conclusion

State Medicaid and SCHIP programs cover more than one in every four children in the United States. As such, these two programs play a crucial role in determining the health care experience of American children overall. Indeed, efforts to improve children's access to care cannot "move the needle" without the contribution of these programs. Research showing both that dental care is integral to general health and function, and that poor children, particularly, suffer from poor oral health and poor access to dental care, bring into sharp focus the imperative to remedy the inadequacies in access to dental care in Medicaid and SCHIP, and the opportunities to do so.

In recent years, numerous states have taken significant steps to improve children's access to dental care in their Medicaid and SCHIP programs, often with meaningful gains in provider participation and children's use of recommended services. The leadership of dental "champions" and dental care coalitions has often been instrumental in these developments. The diverse approaches that states have taken to strengthen Medicaid and SCHIP demonstrate the range and potential of the programmatic and policy levers available to strengthen the systems of dental care serving the children with the greatest needs for care. With this report, states considering action have a set of state experiences to inform and guide them.

While states can do much in Medicaid and SCHIP to increase children's access to dental care, broader-based efforts will ultimately be necessary to improve the oral health of America's low-income children – in addition to proven public health techniques like community water fluoridation. In particular, strategies to expand the supply of oral health care in underserved communities will be vital. Improvements in clinical practice that approach dental disease as an infectious disease and harness disease management techniques are needed as well. In light of their major role in financing and delivering care for children, Medicaid and SCHIP, though they cannot achieve system-level improvements in access to dental care alone, are essential partners in such efforts.

APPENDIX I: Medicaid Payment Rates vs. Regional 75th Percentile of Fees

Fee for a Two-Surface Amalgam Filling

New England Region

Connecticut	\$38
Maine	\$48
Massachusetts	\$80
New Hampshire	\$104
Rhode Island	\$37
Vermont	\$67
Regional 75 th Percentile	\$135

Mid-Atlantic Region

New Jersey	\$36
New York	\$84
Pennsylvania	\$50
Regional 75 th Percentile	\$137

East North Central Region

Illinois	\$48
Indiana	\$73
Michigan (fee-for-service)	\$48
Ohio	\$54
Wisconsin	\$45
Regional 75 th Percentile	\$117

East South Central Region

Alabama	\$60
Kentucky	\$50
Mississippi	\$42
Tennessee	\$76
Regional 75 th Percentile	\$99

South Atlantic Region

Delaware*	—
District of Columbia	\$43
Florida	\$41
Georgia	\$78
Maryland	\$88
North Carolina	\$79
South Carolina	\$75
Virginia	\$57
West Virginia	\$72
Regional 75 th Percentile	\$130

West North Central Region

Iowa	\$55
Kansas	\$64
Minnesota	\$42
Missouri	\$36
Nebraska	\$58
North Dakota	\$62
South Dakota	\$62
Regional 75 th Percentile	\$115

West South Central Region

Arkansas	\$51
Louisiana	\$58
Oklahoma	\$79
Texas	\$44
Regional 75 th Percentile	\$119

Mountain Region

Arizona	\$70
Colorado	\$55
Idaho	\$55
Montana	\$58
Nevada	\$86
New Mexico	\$64
Utah	\$38
Wyoming	\$82
Regional 75 th Percentile	\$129

Pacific Region

Alaska	\$96
California	\$48
Hawaii	\$54
Oregon	\$46
Washington	\$63
Regional 75 th Percentile	\$148

Note: State rates are Medicaid fee-for-service rates.

SOURCES: American Dental Association, *State Innovations to Improve Dental Access for Low-Income Children: A Compendium Update* (Chicago, IL: American Dental Association, 2004); American Dental Association, Survey Center, *2005 Survey of Dental Fees* (Chicago: American Dental Association, 2005).

*Delaware pays 85% of each dentist's billed charges.

APPENDIX II: About the Meeting Participants

The findings contained in this report came from a rich, day-long discussion among a group of 15 experts that included: representatives from eight state agencies that administer Medicaid dental and public health programs; three current and former federal program administrators; one state legislator; two dental school faculty members with expertise in children and people with special health care needs; and a consultant to a state oral health coalition. A variety of clinical backgrounds were represented, including three registered dental hygienists, one pediatric dentist, three public health dentists, two general dentists, one registered dietician, and one physician.

In issuing invitations for the meeting, priority was given to officials from states that have made progress in improving access to dental care in recent years, so that the National Academy for State Health Policy and the Kaiser Commission on Medicaid and the Uninsured could learn from and share their experiences first-hand with policymakers across the country. Two state dental association executives who were unable to attend the meeting submitted comments on the panel findings and priorities afterwards.

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