Increasing Access to Dental Care in Medicaid:
Targeted Programs for Four Populations

California HealthCare Foundation

ISSUE BRIEF

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Introduction

Poor access to oral health care and low use of oral health services by publicly insured people have been persistent problems that states and their Medicaid programs have grappled with for decades. However, there are groups of Medicaid beneficiaries—such as young children, pregnant women, people with developmental disabilities, and people living in rural areas—who face particular threats to their oral health. These populations can benefit from interventions targeted at their specific needs.

This issue brief, which is drawn from a literature review and interviews with stakeholders across the country, describes strategies that several states have used to better address the oral health of these groups, including:[1]

- **Better training for dental professionals:** Dental education often does not adequately train dental students to meet the needs of pregnant women, young children, and people with developmental disabilities, which affects practicing dentists' confidence and willingness to care for these patients. States can use Medicaid's reimbursement process to complement dental education—for example, by tying providers' eligibility for incentive payments to participation in additional training about how to manage the needs of people with developmental disabilities.
- **Care beyond the dentist's chair:** Dental offices are not the only place that oral health services can be delivered. Some, particularly preventive services, can take place in settings that are closer to where people live, work, and learn. Medicaid programs in more than half of states are using pediatricians' and family physicians' offices—where children are treated more often and at younger ages than dental offices—to provide basic oral health services. States such as Oregon are even experimenting with using the offices of the Women, Infants, and Children (WIC) program and having dental hygiene students visit pregnant women and new mothers to provide counseling, oral health education, and supplies.
- **Maximize the power of state contracts:** Medicaid managed care organizations have flexibility that fee-for-service Medicaid programs often do not, including the ability to negotiate payment arrangements for specialty services and to purchase items (such as oral health supplies) that would not ordinarily be reimbursable through Medicaid. States can also negotiate contract provisions that require their dental managed care contractors to ensure that network providers receive supplemental education.
- **Strengthen existing safety net providers:** States can make investments to foster the development of Federally Qualified Health Centers (FQHCs), community clinics that are obligated to provide care to underserved communities. These clinics can obtain higher reimbursements under Medicaid, without the need for legislative action to raise payment rates.

Because such targeted programs are limited in scope, which contains their total cost, they can be pursued in a difficult fiscal environment. They are also aimed at populations that are of specific concern to policymakers, which can make it easier to build the necessary legislative and executive branch consensus. If a state can't achieve comprehensive reform in one leap, targeted interventions can be effective incremental steps along the way.

Findings

This issue brief provides a brief description of the impediments to oral health facing young children, pregnant women, people with developmental disabilities, and people in rural areas, along with the ways in which six states are trying to overcome them. It draws upon a California HealthCare Foundation-funded study by the National Academy for State Health Policy examining the ways that California's state agencies (including Denti-Cal, the state's Medicaid dental program), professional associations, and universities have explored these issues, and further steps the state might take to build upon such efforts. The full text of the study is available at www.nashp.org/files/dental_reimbursements.pdf.

Young Children

Even though the American Academy of Pediatric Dentistry's guidelines recommend that children be seen by a dentist by their first birthday, only 25 percent of children under six years of age saw a dentist in 2004.[2] This is can be attributed to several factors, including the scarcity of pediatric dental specialists, who account for less than 3 percent of all practicing dentists, as well as the limited instruction that general dentists receive in methods for managing young children. Intervention during young childhood is important because cavity-causing bacteria can be established in an infant's mouth by the time the first tooth erupts—between nine months and one year of age. For children with a high risk of oral disease, this infection can quickly progress into rampant decay that can destroy a child's primary teeth soon after they emerge. Healthy baby teeth are crucial for the transition from milk to solid food, for developing speech, and for the proper emergence of permanent teeth. Moreover, decay in primary teeth—particularly molars—is a predictor of decay in permanent teeth, because oral bacteria persist in the mouth as permanent teeth grow in.[3] Providing appropriate and timely preventive care can help eliminate unnecessary pain and avert future disease.

Programs in Other States

- North Carolina's early prevention program for children under age three, Into the Mouths of Babes, developed out of a local recognition that infants and toddlers received care in the medical office far earlier and far more often than in the dental office. This insight has developed into a multi-pronged effort to train physicians to identify the signs of oral disease, provide oral health education and preventive services such as fluoride varnish, and arrange appropriate referrals of children with treatment needs to dentists. The program moved from a pilot project in the state's Appalachian region to a statewide initiative with the introduction of Medicaid reimbursement. Medicaid pays $54 per visit for as many as six visits, up to age three and a half. The number of children served has grown from 8,300 in 2001 to more than 57,000 in 2007.[4] Preliminary data shows reductions in treatment-related expenditures (such as fillings) in front teeth for children receiving four or more visits.[5] The state's strong partnership between Medicaid, public health agencies, providers, academics, and community organizations continues to refine the methods for identifying children at highest risk and improve physicians' ability to refer them to dentists successfully.

- Rhode Island's RIte Smiles program involves a specialized dental managed care contract to pay higher reimbursement rates for pediatric services, recruit more private dentists to provide them, and train them in techniques for managing young

children. Because the state's budget did not allow for the simultaneous introduction of coverage to all children under 18, it focused on those born after May 1, 2000. To finance the program, the state has rebalanced the funds in its dental budget—for example, tightening the criteria for covered orthodontic services. In RIte Smiles first year of operation, participation among dentists has grown from 27 to 217 (out of about 500 in the state), and use of services among has increased, particularly among the oldest children in the eligible group.[6] Using a phased-in approach, the state is hoping to gradually expand this RIte Smiles coverage to all of its Medicaid-enrolled children.

Programs in California

- Since 2003, the Healthy Kids, Healthy Teeth (HKHT) program in Alameda County has paid higher reimbursement rates to providers who complete a training program and treat children five and younger. While enrollment numbers have been small (under 2,500), state officials report that the service utilization rate for this group is substantially higher than other Alameda County Denti-Cal beneficiaries. This is particularly true among very young children: More than 50 percent of one-year-olds enrolled in HKHT have had an oral health visit, compared to less than 10 percent for non-enrolled children; among two-year-olds, the comparative use rates are 40 percent and 20 percent.[7]

- The California Dental Association Foundation has a program to train general dentists to treat infants and young children. Called the Pediatric Oral Health Access Program, it has set the goal of providing access to dental services for 50,000 young children by 2010.[8]

- Seeking to integrate oral health messages and preventive services into the practice of primary care, Medi-Cal began reimbursing physicians for fluoride varnish application in June 2006, an effort that was followed in April 2007 by an additional push to improve participation among Medi-Cal managed care plans. Payment under the fee-for-service Medi-Cal program is $18 per application for up to three applications per year (managed care plans set their own reimbursement rates).[9]

Pregnant Women

Mothers are the primary route of transmission of the bacteria that cause cavities in children (usually through actions that involve the mother's saliva, such as sharing a spoon for tasting baby food). Providing dental care to pregnant women can reduce the risk of dental disease for their children, both by lowering the rate of exposure and by teaching mothers good oral health habits that they can pass along to family members.[10] Moreover, a growing body of research suggests a link between untreated gum disease and adverse birth outcomes such as preterm birth or low birth weight.[11] Despite disagreement in the research community regarding the extent and even the existence of this "perio-systemic" link, state Medicaid programs have begun to focus on dental coverage for their pregnant enrollees because of the potential for savings. An eighth of all births are low-birth weight or pre-term, and Medicaid pays for 42 percent of these. Pre-term births cost an average of $65,000, and low-birth weight children are at an increased risk for conditions such as cerebral palsy and mental retardation.[12] If treating oral infections reduces the number of pre-term or low-birth weight deliveries even by a small percentage, there is potential for states to enjoy cost savings immediately and avert future medical expenditures.

Programs in Other States

A WIC-based pilot program in Klamath County, Oregon, hopes to show that providing intensive dental care and oral health education to pregnant women and new mothers will improve the health of their children, both by raising their oral health literacy and intervening in the primary route of transmission for cavity-causing bacteria.

Two Medicaid dental managed care contractors are paying for the program, including items not ordinarily covered under Medicaid, such as toothbrushes, toothpaste, and floss. Students from a dental hygiene training program bring training materials and oral health supplies as part of home visits to pregnant women and new mothers and arrange for the women to receive preventive services at the program's hygiene clinic. Women found to have their own treatment needs are referred to dentists in the managed care plans' networks to receive services geared toward eliminating active "reservoirs of disease." Between 2004 and 2006, 503 women in the county were identified as pregnant and eligible for Medicaid coverage. Of these, 339 received home visits and 235 were treated at the dental hygiene program or dental offices, a large improvement from the 8.8 percent of Medicaid-enrolled pregnant women statewide who received dental care in 2001. Preliminary data show a positive impact on the oral health of the children in the county, and a larger experiment to confirm these findings is underway in four more counties.[13]

Programs in California

Medi-Cal provides comprehensive dental benefits to enrolled children and adults, including pregnant women, that are among the most comprehensive in the nation (see the discussion about Medi-Cal adult dental benefits and the California budget on page 6). There are two segments of pregnant women in the Medi-Cal population — those who are eligible for the full scope of benefits, and those who are eligible only for services directly related to their pregnancy. This latter group receives a limited package of services including cleanings, fluoride applications, periodontal services, and emergency dental care — all of which are paid for solely with state funds. "Full scope" pregnant women qualify for all Medicaid services, including more types of dental care, such as restorative treatment. Pregnant women are also exempt from the state's $1,800 annual adult benefit limit for cleanings, fluoride applications, and periodontal services.[14] Still, as recently as 2004, less than 20 percent of Denti-Cal-enrolled pregnant women (counting both "full scope" and "pregnancy-only" enrollees) used these oral health services.[15]

People with Developmental Disabilities

People with developmental disabilities suffer more dental disease than other people. They have more missing teeth and encounter greater difficulty in locating dental care than other segments of the Medicaid population. What's more, people with severe developmental disabilities often cannot accurately express when they are experiencing dental pain or discomfort. Caregivers may not be able to make a connection between signs of distress, such as not eating or fighting, and an untreated dental problem. There is an extremely limited pool of dentists who specialize in "special care" dentistry for people with disabilities, even including pediatric dentists, the small number of geriatric dentists, and dentists who provide services in hospitals.[16] Providing dental care to people with developmental disabilities requires extra time and special management skills that general dentists are not required to develop.

Programs in Other States

- New Mexico has built a corps of community dentists who are specially trained to provide the more involved and time-intensive care that people with developmental disabilities need. Its Special Needs Code program directs an additional payment of $97 per dental visit to dentists completing on-line study and in-person training with special care dentists. Since the program's inception in 1995, the state has developed a small but dedicated corps of 40 dentists who have completed Special Needs Code training. Over the course of the program, over 37,000 patient visits have been supplemented by the program. In fiscal year 2006, three thousand people with developmental disabilities made more than 6,100 visits to dental offices.[17]

- In Pennsylvania, Medicaid managed care organizations are contracting with a specialized dental practice to provide care to people with severe disabilities who require sedation or general anesthesia. This practice, called Special Smiles, Ltd., negotiated with the four Medicaid managed care organizations operating in southeastern Pennsylvania for a "global budgeting" arrangement under which it sees about 1,000 patients per year in an operating room setting for a fixed cost. Since the program began in 2001, more than 5,000 full-mouth rehabilitations have been performed.[18] In fee-for-service areas of the state, a new pay-for-performance program offers financial incentives for dentists to provide dental disease management to pregnant women, young children, and people with chronic conditions.[19]

Programs in California

- The California Statewide Taskforce on Oral Health for People with Disabilities and Aging Californians has been working for several years to introduce a program modeled on New Mexico's Special Needs Code. The group, organized by faculty at the University of the Pacific's Dugoni School of Dentistry, has developed a set of 31 recommendations across six domains, including the creation of improved incentives for oral health professionals to care for people with disabilities. The group proposes a training program that would provide dentists with 20 hours of instruction, followed by ten hours of hands-on experience. After the completion of this training, the dentist would be certified to receive an additional $85 "behavior management" fee when treating enrollees with developmental disabilities. The group estimates that, if the incentive increased visits for the 370,500 enrollees in "disabled" enrollment codes by 25 percent, the state would incur approximately $31 million in additional expenditures, an increase of less than 5 percent in Denti-Cal expenditures.[20] The CDA Foundation has secured grant funding to conduct a demonstration project that will collect clinical and economic data.[21]

- In addition to its comprehensive dental benefit for adults, Denti-Cal exempts dentists treating developmentally disabled enrollees from prior authorization for restorative services, if there is evidence of decay on an x-ray.[22]

People in Rural Areas

People in rural areas have significantly poorer oral health than urban populations, including higher rates of untreated dental decay, lower frequency of visits to dentists, and a higher probability of losing all their natural teeth. Rural areas are less likely to have community water systems, which in turn lowers their access to water fluoridation, one of the major public health tools for preventing tooth decay. Rural populations also tend to be older, have poorer overall health status, and have higher rates of poverty. Residents must often travel farther for care, an inconvenience which may be compounded by a lack of public transportation. Simply finding a local provider at all can be a challenge. A report by the National Rural Health Association found that of the approximately 150,000 general dentists practicing in the United States, only 14 percent work in rural areas. And of the 2,235 federally designated "dental supply shortage areas" identified in 2003, 74 percent were located in regions categorized as "non-metropolitan."[23]

Programs in Other States

Wisconsin is using relatively modest direct budget appropriations ($632,000) to build up FQHCs in the rural areas in the north of the state. Federal law requires state Medicaid programs to pay FQHCs reimbursements that at least equal their reasonable costs of providing care. Medicaid cost-based reimbursements have helped these clinics to sustain large group practices that increase Medicaid enrollees' use of care and brings that care closer to home. Dental use among Medicaid-enrolled patients from Rusk County (population: 15,347), where the

17-chair Ladysmith Dental Clinic opened in November 2002, has risen to almost 40 percent, compared to a statewide rate of less than 25 percent in 2003. The improvement is particularly marked for adolescents: More than half of 6 to 14 year olds received services in each of the past three years, compared to a less than 40 percent in 2001. This model is being replicated in half a dozen communities across northern Wisconsin.[24]

Programs in California

Since 1998, the state's Managed Risk Medical Insurance Board (MRMIB) has funded a variety of dental enhancement projects under the auspices of its Rural Health Demonstration Projects program. This program uses the State Children's Health Insurance Program (SCHIP) to match state money with federal funds, at a 35/65 split. In state fiscal year 2006, the legislature allocated more than $2.8 million to the program, which resulted in total funding of $5.75 million for projects in telemedicine, mental health, obesity, asthma, and several other areas. MRMIB funds a number of SCHIP dental managed care plans, including Access Dental, Premier Dental, and Delta Dental, to supply mobile dental vans, place additional providers in rural areas, and provide extended clinic hours on nights and weekends.[25]

Conclusion

California faces challenges similar to many other states in providing dental care to the underserved. The state is well poised, however, to make targeted investments in improving services for the populations profiled in this issue brief. California's state agencies, universities, and communities are already pursuing or developing a variety of efforts that can be built upon using promising models from other states.

It is important to note that many of the state programs described here are possible because the states chose to provide a comprehensive Medicaid adult dental benefit. As of this writing, California's adult dental benefit has been eliminated in the 2008–2009 budget special session.[26] However, these and other eliminated optional benefits may be restored on or before April 1, 2009 if funds from the federal economic stimulus plan are deemed "sufficient" by the State Treasurer and the Department of Finance. If the eliminated benefits are not restored, cuts go into effect on July 1, 2009.

As California and other states have shown, it is possible to make modest programmatic and reimbursement changes to direct and tailor services to the underserved. Yet despite some programs that target these special populations, there remain millions of Californians with serious unmet oral health needs and access challenges. Policymakers, advocates, and providers should continue to study innovations in other states with an eye toward how they might be implemented in California.

About the Author

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Endnotes

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