



Rapid Public Health Policy Response Project

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Pediatric Dentistry: How Can Dental Care for Low- Income Children Be Improved?

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How Can Dental Care for Low-Income Children Be Improved?

About this Paper

A “silent epidemic” of dental and other oral diseases disproportionately affects the nation’s most vulnerable children. This paper describes the causes and consequences of the problem, and the many strategies available to address it.

Unmet dental needs can cause severe infection, acute pain, and lifelong illnesses, and have long-term consequences for development, affecting school performance, self-esteem, and nutrition. Occasionally, dental disease can turn deadly. Twenty million children have no dental insurance at all. While Medicaid requires that dental benefits be covered for all enrolled children, most dentists do not accept this insurance, and caregivers often experience great difficulty accessing treatment for Medicaid-insured children.

Strategies for increasing access to dental care include increasing Medicaid reimbursement rates to dentists and streamlining program administration; expanding the dental safety net through SCHIP, health centers or other providers; broadening the provider network; enhancing consumer and provider education; and replicating the many state-level models that have been developed.

For more information about pediatric dental health issues:

Anne Markus, JD, PhD, MHS
Associate Research Professor, Department of Health Policy
School of Public Health and Health Services
The George Washington University
2021 K Street, N.W., Suite 800
Washington, D.C. 20006
(202) 530-2339
armarkus@gwu.edu

About the Rapid Public Health Policy Response Project

The Rapid Public Health Policy Response Project of the School of Public Health and Health Services at The George Washington University presents data and other background information on breaking public health stories. The goal is to educate the public, policymakers, legislators, health care providers, the media and others in order to promote informed decision making.

Karyn Feiden, an independent consultant who writes about public health and health care, provides editorial support for this project. Alexandra Stewart, JD, an assistant research professor in GW’s Department of Health Policy, oversees the research. Financial support comes from the Public Health and Policy Group of Pfizer, Inc.

Pediatric Dentistry: How Can Dental Care for Low-Income Children Be Improved?

The nation is beset by a “silent epidemic” of dental and other oral diseases that disproportionately affects the nation’s most vulnerable populations, according to the U.S. Surgeon General.¹ The death in early 2007 of Deamonte Driver, a twelve-year-old Maryland boy, whose untreated tooth infection had spread to his brain, briefly focused the nation’s attention on this epidemic.

Public interest was stirred again later in November when *ABC News* reported on a five-month investigation into Small Smiles, a national dental chain that provides a high volume of care to children on Medicaid.² Reporters claimed that young patients were being inappropriately restrained and that staff was given bonuses for persuading parents to accept unnecessary dental services for their children.

And in December, *The New York Times* ran a compelling article on the dental problems in Kentucky, reporting that one in 10 people have no teeth and half the state’s children have untreated cavities.³

Behind these dramatic stories lie the unmet dental health needs of the nation’s poorest children. While the overall oral health status of most Americans has improved significantly over the past five decades, the Surgeon General reports “profound disparities” in dental disease by income, race and ethnicity.¹

How can dental care for low-income children be improved?

A Case Study of Disparities

Dental cavities are “the most common chronic disease of childhood,” and five times more common than asthma.¹ But cavities — and a host of other oral health problems — are closely linked to socioeconomic status and ethnicity.

Approximately 25 percent of children, ages 5 to 17, account for 80 percent of the cavities in permanent teeth, according to the U.S. General Accounting Office. The GAO also reports that most of these cavities occur among low-income and otherwise vulnerable populations.⁴ A survey of children’s oral health, conducted as part of the broader National Survey of Children’s Health in 2005, likewise highlights a connection to poverty:⁵

- Fewer than half of children in families living below the federal poverty line reported that their teeth were in either “excellent” or “good” condition, compared to almost 83 percent of children whose family incomes were 400 percent of that line, or higher.
- Not surprisingly, those figures correlate with the use of preventive dental care. Only 58 percent of children in poor families received recommended preventive care in the year prior to the survey, compared with 82 percent of children in the well-off group.

Moreover, there are signals of a worsening problem. In 2007, the Centers for Disease Control and Prevention (CDC) reported that decay in primary (“baby”) teeth among children, ages two to five, had jumped from 24 percent in the period from 1988 to 1994 to 28 percent in the 1999–2004 period.⁶

“The upturn in cavities among young children portends a new wave of increased tooth decay,” states the Washington-based Children’s Dental Health Project. “Early tooth decay is a predictor of future tooth decay.”⁷

The Consequences of Dental Disease

The consequences of dental and other oral problems are far-reaching. “The daily reality for children with untreated oral disease is often persistent pain, inability to eat comfortably or chew well, embarrassment at discolored and damaged teeth, and distraction from play and learning,” explains the CDC.⁸

And that’s only part of the problem. The mouth is the portal through which hundreds of pathogens can enter. Without good dental habits and regular care, the oral cavity is susceptible to a host of bacterial, viral, and fungal invaders. While tooth decay and other local diseases are the most common results, the tragedy of Deamonte Driver underscores the potential consequences when untreated infection spreads through the bloodstream or lymphatic system. It also hints at the cost — before he died, the health care system spent more than \$250,000 on the boy’s medical care.⁹

School performance is another casualty of dental problems. Children lose 51 million hours of school every year to dental-related illnesses⁸ and an array of school-related problems have been documented, including difficulty concentrating and poor performance.¹⁰

The foundation for dental problems among adults — and their often-severe psychosocial and physical consequences — is often laid down in childhood. Among other risks, the U.S. Surgeon General reports on research demonstrating a relationship in later life between oral health and:

- **Self-esteem and emotional well-being.** For example, several studies show an impact of oral health problems on romantic relationships and the inclination to engage in conversation or to smile.¹¹
- **Education and professional achievement.** In 1996, Americans lost a total of 2.4 million work days as a result of acute dental conditions (a relatively small percentage of the total 360 million lost work days, but sizable nonetheless).¹²
- **Poor nutrition and disrupted sleep patterns.** In one study of an elderly population in North Carolina, for example, 18 percent of African-Americans said they had difficulty chewing food (compared to 6 percent of the white population surveyed).¹³

- **Diabetes, heart disease, stroke and poor pregnancy outcomes.** With knowledge accumulating about the mechanisms of a possible cause-and-effect relationship between oral disease and these health conditions, the Surgeon General has recommended “a comprehensive and targeted research effort” to learn more.¹⁴

Unmet Needs for Pediatric Dentistry

The Kaiser Commission on Medicaid and the Uninsured has called pediatric dental care “the most prevalent unmet health need among children, regardless of insurance status.” The barriers are greatest for the more than 20 million children without any kind of dental insurance (by comparison, nine million lack medical coverage).¹⁵

The distribution of dentists is also a concern. More than 2,200 regions in the United States — 74 percent of them outside the nation’s metropolitan areas — have been designated “dental health professional shortage areas” by the federal Health Resources and Services Administration.¹⁶ Thirty-one million people live in those areas, where 4,650 additional dentists would be needed to provide adequate services.¹⁷ Yet the nation’s supply of dentists has been shrinking for two decades, a trend that is expected to continue for at least another ten years.¹⁸

The Reach of Public Programs: Some 28 million children in low-income families receive insurance coverage through Medicaid.¹⁵ Federal mandates require all states to provide dental services to Medicaid-eligible individuals under the age of 21 as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid’s comprehensive health program for children.¹⁹

The mandate emphasizes preventive care. According to the federal Centers for Medicare & Medicaid Services:

“Dental services must be provided at intervals that meet reasonable standards of dental practice... Services must include at a minimum, relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services for EPSDT recipients.”²⁰

An additional six million children are covered through the State Children’s Health Insurance Program (SCHIP), which typically provides care for families whose incomes are too high for Medicaid eligibility and too low to be able to afford private insurance.¹⁵ Most states provide dental coverage through SCHIP, although it is not a mandated benefit and the nature and extent of the coverage differs dramatically.

Medicaid and SCHIP both make measurable contributions to the dental health of children. Based on its health insurance data, the Kaiser Commission concludes that 71 percent of children insured through public programs saw a dentist in the past year,

compared with 45 percent of uninsured children.¹⁵ In general, SCHIP has been more effective. A North Carolina study of preschoolers, ages one to five, concluded that children who are enrolled in SCHIP have a 22 percent greater use of dental services than those enrolled in Medicaid.”²¹

The Limits of Medicaid: The primary obstacle to pediatric dental care for Medicaid-eligible children is that most dentists do not accept it. And even those who participate in the Medicaid program often limit the number of beneficiaries they will serve. The results in Maryland are typical of a broader national problem — fewer than one-third of the 500,000 children who receive Medicaid services in that state saw a dentist in 2006.²²

An older study by the GAO found that in 1999:²³

- Only five states (of 31 providing information) said that more than 25 percent of their dentists treated at least 100 Medicaid patients.
- In 23 states (of 39 providing information), fewer than half the dentists had seen even one Medicaid patient.

Dentists consistently offer three reasons for not participating in Medicaid:

- **Low reimbursement rates:** Based on a survey of all 50 states, the GAO found significant discrepancies in the payments Medicaid makes for 15 dental procedures, compared to the average fees charged in the region.²³ In the 13 most generous states, Medicaid paid above two-thirds of the regional fees, but most states paid significantly less. In the District of Columbia, Medicaid paid between 22 and 55 percent of regional averages for the 15 procedures.
- **Burdensome administrative requirements:** Dentists complain about Medicaid’s procedures for handling claims, verifying eligibility, authorizing services, and making payments.²³ The American Dental Association (ADA) notes that Medicaid programs “are often administered in a much more complex, unfamiliar and unusual manner than private and commercial dental benefit programs.”²⁴
- **Broken appointments and non-compliant patients:** Dentists perceive that Medicaid patients are more likely than patients with private insurance to break their appointments, which they find particularly annoying because Medicaid does not allow providers to charge for them.²³

Other barriers were highlighted in a series of 11 focus groups with caregivers, mostly mothers, in North Carolina who had attempted to access dental care for their Medicaid-insured children.²⁵ Participants reported difficulties finding providers, scheduling appointments and arranging transportation. Once they actually reached a dentist’s office, complaints about language barriers, racial discrimination and demeaning treatment were also widespread.

Still another obstacle is that many families frequently lose and regain Medicaid eligibility as a result of paperwork problems or changes in their work, health or immigration status. The family of Deamonte Driver had lapsed coverage, for example, although the boy's mother said the family had been unable to find adequate dental care even with Medicaid.²⁶

Strategies to Increase Access

The role of pediatric dental care in overall health, coupled with the well-documented deficiencies in access, underscore the need to reach more children with appropriate dental services. There are many opportunities to do that.²⁷

The American Dental Association has said that increasing Medicaid reimbursement rates to more closely mirror the marketplace is “one of the most critical strategies for improving access to oral health.”²⁴

But GAO data suggest this is only a partial solution. Between 1997 and 2000, 40 states increased their Medicaid payments to dentists and 15 reported no resulting increases in the number of dentists accepting Medicaid or the number of Medicaid-insured patients accessing dental services (14 states did see increases and 11 did not have data available). Higher reimbursement levels worked best — the states paying at least two-thirds of the average fees in the region reported the most significant increases.²³

Expanding dental benefits through SCHIP is another option. Two versions of SCHIP reauthorization legislation, both vetoed by President George W. Bush in the fall of 2007, would have required all states to cover a package of dental services, including prevention, for the first time.²⁸ In December, the president signed a bill extending the existing SCHIP program (without a mandated dental benefit).²⁹

There may also be opportunities to provide more dental care through federally qualified health centers, which serve 16 million people, approximately one-third of them children, at 5,000 locations around the country.³⁰ These numbers translate into one-quarter of all poor children in the United States.³¹ In 2006, approximately 5.16 million patient visits were made to 1,900 health center staff dentists.³² Congressional legislation introduced in May, 2007 would make additional funds available for pediatric dental services in health centers, although the shortage of providers in many of their communities will likely remain.¹⁷

To fill that gap, some have proposed training various levels of dental health aides, including dental therapists who can drill cavities, extract teeth, and provide other primary oral health care services.³³ Dental therapists are widely used elsewhere in the world, and were considered for reaching native tribes in Alaska, but the American Dental Association has opposed their use.³⁴

The ADA describes other state-level activities more enthusiastically, including model programs that improve access to dental care by restructuring Medicaid in various ways

or adding community-based services.²⁴ For example, Michigan has developed a Medicaid fee-for-service children’s dental program administered by a single commercial vendor while Alabama administers its own fee-for-service program, which includes targeted dental case management. In Vermont, private dental services operate with public subsidies and Connecticut has outlined opportunities for health centers to contract with private-sector dentists.

Another package of initiatives was developed under the State Action for Oral Health Access initiative, launched in 2002 by the Robert Wood Johnson Foundation.³⁵ Programs developed in six states — Arizona, Oregon, Pennsylvania, Rhode Island, South Carolina and Vermont — were designed to test and evaluate new strategies for meeting the dental needs of low-income children and adults.³⁶

These fall into five categories:

- > Developing value-based purchasing strategies.
- > Broadening the provider network.
- > Expanding the dental safety net.
- > Creating a dental home.
- > Enhancing consumer and provider education.

For example, Rhode Island has created a dental benefits manager program to guide Medicaid recipients to care and an internship program to train welfare recipients as dental assistants. Pennsylvania has developed training for “expanded function dental assistants” while Oregon is targeting pregnant women by creating “dental homes” in which they can receive consistent education and care.

While the appropriate combination of these approaches will surely require further debate, the importance of improving pediatric dental health for the nation’s most vulnerable children surely does not.

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