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COMMUNITY EFFORTS TO EXPAND DENTAL SERVICES FOR LOW-INCOME PEOPLE

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Poor oral health among low-income people is gaining attention as a significant health care problem. Key barriers to dental services include low rates of dental insurance coverage, limited dental benefits available through public insurance programs, and a lack of dentists willing to serve low-income patients, according to findings from the Center for Studying Health System Change's (HSC) 2007 site visits to 12 nationally representative metropolitan communities. Communities are attempting to provide more dental services to low-income residents. Along with state efforts to increase dentists' participation in Medicaid and the State Children's Health Insurance Program (SCHIP), hospitals, community health centers, health departments, dental schools and others are working to expand dental services, with some focusing on basic preventive services and others pursuing more comprehensive dental care. Many community efforts rely on increasing the number of dental professionals available to treat low-income people. Without additional involvement from the dental community and state and federal policy makers, however, many low-income people likely will continue to lack access to dental care and suffer the consequences.

Low-Income People Lack Dental Coverage and Care

Recognition of the importance of oral health has grown since the U.S. Surgeon General's 2000 report, which highlighted the prevalence of poor oral health among low-income groups and stressed that oral health is essential to overall health.[1] There is an apparent linkage between some oral infections and several systemic medical diseases, including heart and lung disease, stroke, and premature births. Further, abscessed teeth can cause severe infections and even death, as exemplified in 2007 by the widely publicized case of Deamonte Driver, a Maryland boy who died from a tooth infection that spread to his brain.

Lack of dental care is the key contributor to oral health problems, with low-income people and some racial and ethnic minorities facing particular barriers to care. According to the Agency for Healthcare Research and Quality's 2004 Medical Expenditure Panel Survey (MEPS), approximately 40 percent of people living in poverty—those with incomes at or below $21,200 for a family of four in 2008—lacked dental coverage during the year, compared to approximately a quarter of people earning more than four times the poverty level. The 2005 MEPS indicates that approximately a quarter of people living in poverty had a dental visit during the year, compared with more than half of people with incomes above 400 percent of the poverty level. Likewise, approximately a quarter of Hispanics and blacks had a dental visit during the year, compared to almost half of whites.

HSC's 2007 site visits to 12 communities (see Data Source) found that dental care is one of the most difficult health care services for low-income people to obtain, largely because of difficulties finding dentists who will accept public insurance or provide charity care. Additional barriers for low-income people may include a lack of awareness of the importance of dental health to overall health and perceptions that dental care is more of a luxury than a necessity.[2] As a community health center respondent explained, "If you weren't raised to get your teeth cleaned, you won't do it."

Given barriers to care, many low-income people do not receive preventive dental care or treatment for an oral health problem until an infection or other urgent condition develops. Diseased teeth are often extracted rather than restored.

State Medicaid and SCHIP Policy Affects Dental Access

State Medicaid and SCHIP policy plays a significant role in access to dental services at the community level. Although states are required to provide comprehensive dental coverage to children enrolled in Medicaid, dental coverage for children in SCHIP and

for adult Medicaid enrollees is optional. While most states include some level of dental coverage through SCHIP, Medicaid coverage for adults varies greatly by state and is often limited to emergency services, with the comprehensiveness of coverage often fluctuating with state budgets. In 2006, when state budgets were relatively healthy, Florida started providing limited dental coverage for Medicaid adults and Massachusetts added two cleanings and exams a year in addition to emergency dental treatment coverage for adults.

Even when Medicaid and SCHIP provide dental coverage, low reimbursement rates often impede dentists' participation. Although Michigan restored a previous cut in routine dental services for adults in 2006, dentists' participation had declined significantly, leaving only 15 percent of dentists in the state accepting adult Medicaid patients.[3] A Lansing respondent observed, "Patients thought they were going to get care, but they couldn't because no one would see them."

Increased payments that approach private insurance rates or dentists' charges have contributed to an uptick in participation by dentists in some communities, including Little Rock, Phoenix and Syracuse. While New York's 250 percent increase in dental reimbursement rates initially had little impact, it eventually prompted a few private dental practices in Syracuse to participate; in particular, a dental practice chain that focuses on treating Medicaid and SCHIP children opened two facilities in Syracuse. New Jersey—which traditionally has had among the lowest Medicaid payment rates in the nation—recently increased reimbursement for children's dental services by 350 percent, putting Medicaid rates on par with private rates, although the impact of the change remains to be seen.

Along with raising reimbursement rates, simplifying administrative processes, such as claims processing, has been found to help improve dentists' participation in Medicaid and SCHIP and access to care for enrollees.[4] To do so, some Medicaid programs, such as Michigan's Medicaid program for children, have contracted with commercial dental insurance plans.[5] Yet, adequate payment remains key: Florida's managed care pilot for children's dental services resulted in a significant decline in dentists' participation and utilization of care because of low capitated payments relative to the previous fee-for-service rates.[6]

Despite these changes, other challenges low-income people face, such as keeping appointments, reportedly contribute to some dentists' reluctance to treat them.[7] As a Syracuse respondent said, "The reimbursement increases were still not encouraging dentists to accept Medicaid patients. It turns out it was more of an issue of having the 'unwashed' in the waiting room, problems scheduling and noncompliant patients."

Significant Gaps in the Dental Safety Net

Low-income patients who cannot find private-practice dentists to treat them often turn to safety net providers. However, the safety net for dental care is considerably less extensive than the safety net for medical care more broadly, and few dental providers focus on serving low-income people. Also, dental care traditionally has not been a core focus of general safety net providers—public and not-for-profit hospitals, community health centers, free clinics and local health departments—and their capacity is limited.

Hospital emergency departments (EDs) serve as de facto dental care providers. ED directors in Lansing, Miami and Seattle, in particular, reported high demand for dental services. The Emergency Medical Treatment and Labor Act (EMTALA) requires ED staff to screen and stabilize all patients, including those with dental conditions, although most EDs do not have the staff or equipment to provide dental services and are often limited to providing pain relief. However, some EDs in Syracuse, northern New Jersey and Boston benefit from having dental residents on call through their hospitals' oral surgery or general practice dental residency programs.

Although some hospitals have dental clinics staffed by dental residents or volunteer dentists, services often are limited. As a Boston hospital CEO said, "There is infinite demand for dental services…Every Tuesday we have people lining up to have their teeth pulled." Although some hospitals are expanding dental clinics, others question whether they should continue providing dental care, particularly as other types of residency programs and services generate more revenue. Seattle's public hospital recently downsized its general dentistry clinic, after determining those services to be outside of the hospital's core mission.[8]

Community Efforts to Expand Dental Services

Many communities are working to expand dental services for low-income people. These efforts range from providing preventive care—including cleanings, X-rays, fluoride treatment and sealants to prevent tooth decay—to filling cavities and providing other restorative services, and, in some cases, offering rehabilitative services, such as orthodontics and periodontics. Funding support for these services and participation from dental students and professionals are integral to these efforts.

Preventing dental problems. A number of communities provide preventive care and general dental education to schoolchildren, as such efforts are relatively low cost compared with the cost of treating future dental problems, and providing services at school removes some of the barriers associated with scheduling appointments. For example, students from a Cleveland dental school provide preventive care at local elementary schools, while the county health department in Miami operates a dental van that visits schools. In Syracuse, community advocates are working to re-establish the county's school-based preventive dental program, which was discontinued after a cut in state funding.

Communities often rely on dental hygienists to support their preventive programs. Hygienists are less expensive and typically more available than dentists, in part because of recent expansions of training programs.[9] A number of states now allow dental hygienists to provide certain preventive services to low-income people in public facilities without the direct supervision of a dentist. For instance, community activists in Arizona lobbied successfully to change licensure laws to allow hygienists to provide preventive treatments to low-income children without supervision.[10]

Yet, preventive programs need resources in place to treat dental problems identified during exams. Directors of the Cleveland school-based program have attempted to address this issue by partnering with local dental societies to generate a list of dentists willing to provide follow-up treatment.[11] However, community programs that coordinate physicians and dentists willing to volunteer their services for low-income people typically have limited capacity. Through such a program in Little Rock, the wait for a dental appointment reportedly is several years. While advocates in some communities, such as Miami, propose advanced training for hygienists or other dental personnel to perform certain restorative treatments, state and national dental associations are largely opposed to such expansions in scope of practice, citing safety concerns.[12]

Providing comprehensive services. Federally qualified health centers (FQHCs) and other community clinics are increasingly offering dental services, including preventive, restorative, emergency and, in some cases, rehabilitative services. In particular, such health centers are key providers for racial and ethnic minorities and immigrants. With the support of federal grants, the volume of dental services provided by FQHCs grew 85 percent between 2000 and 2005; by 2006 approximately three-quarters of FQHCs provided preventive dental care.[13] Health centers or community clinics in half of the 12 communities reported increasing capacity, for example, by opening new dental clinics, expanding clinic sessions and/or hiring new dental staff over the last few years. FQHCs receive enhanced Medicaid reimbursement, which helps generate the revenues to support these expansions.

However, health centers report that expansions to date do not approach the level of need, and waits for appointments remain long. Respondents in northern New Jersey and Seattle reported that the wait for an adult to see a dentist is often two to three months, even for extractions of diseased teeth. As a health center respondent from Indianapolis explained, "We have three [patient treatment chairs]. I could probably double those and still not have enough capacity." Yet, federal dental expansion grants to FQHCs have waned in recent years.

Recruitment challenges also hinder additional expansion of dental capacity because health centers and community clinics often cannot offer competitive compensation. Although health centers receive dentists from the National Health Service Corps, which places dentists in underserved areas in exchange for student loan repayment, approximately 40 percent of urban health centers have reported it is very difficult to recruit dentists.[14] Health centers in Little Rock, Syracuse and northern New Jersey reported significant problems recruiting dentists.

Developing community collaborations. Similar to their role in prevention efforts, dental schools are partnering with health centers to enhance training opportunities for students and increase dental services for low-income people. Training in community clinics typically enables students to treat more low-income patients than they would in dental school clinics.[15] Health centers in Lansing, Indianapolis and Phoenix have such arrangements with local dental schools. Dental students have had a particular impact on access in Phoenix, where two new dental schools have an explicit focus on serving the community.

Although lacking a dental school in the area, Greenville recently created a dental program through a broad partnership with the technical college (which trains dental assistants and hygienists), the FQHC, a local hospital, and corporate and foundation support. The effort raised more than $1.6 million to care for 3,000 Medicaid and uninsured patients the first year. Care is provided through the FQHC's fixed dental practice and a fully equipped mobile unit donated by the hospital, which brings dental professionals to churches, schools and other community sites. Students and faculty provide preventive services in exchange for training space, and three dentists employed by the health center provide restorative services. The health center's enhanced Medicaid payments are expected to help sustain the program.

Implications

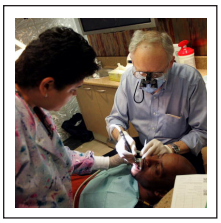
Community efforts to meet the dental service needs of low-income residents face an uphill battle because demand for services far exceeds available resources. Policy makers could consider a number of options to improve access to dental care through both public and private providers.

Additional state efforts to improve Medicaid and SCHIP payment rates and reimbursement processes could help expand the number of dentists willing to serve low-income people. Recent gains in dentists' participation in some communities could erode if public payment rates are not adjusted as private fees increase.[16] Yet, state spending on dental services is threatened by competing priorities and the current economic downturn and decline in tax revenue in many states. Policy makers also might examine whether targeted incentives to large dental practices that specialize in the particular needs of low-income patients—as seen in Syracuse—could help expand access in a cost-effective way.

Additional National Health Service Corps dentists, dental expansion grants for FQHCs and other federal efforts could help build community capacity. Prompted by the death of Deamonte Driver, several pieces of federal legislation aimed at improving dental access, particularly for children, are under consideration. One called "Deamonte's Law" would attempt to increase the number of pediatric dentists and expand community health center dental capacity. Additional proposals include providing grants to states to improve Medicaid and SCHIP dental programs, offering tax credits to dentists who serve low-income children and establishing a working group of representatives from federal health and human service agencies to coordinate the use of resources and identify best practices regarding oral health programs.

Collaboration among policy makers, safety net providers, national and state dental associations and dental schools could help address gaps in the dental workforce. For example, the Robert Wood Johnson Foundation and The California Endowment are funding an initiative to help dental schools recruit more minority and low-income students and to place more dental students and residents in community clinics.[17] Further, the debate continues about the level of care hygienists should be allowed to provide without the supervision of a dentist and whether other non-dentist professionals could safely fill cavities and extract teeth; such training programs are developing in Minnesota and Alaska.[18]

In addition, the overall supply of dentists should be examined, since the number of practicing dentists has not kept pace with



Data Source

Approximately every two years, HSC conducts site visits to 12 nationally representative metropolitan communities as part of the Community Tracking Study to interview health care leaders about the local health care market, how it has changed and the effect of those changes on people. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. The sixth round of site visits was conducted between February and June 2007 with 453 interviews. This Issue Brief is based on responses from state Medicaid executives and other policy makers, community health centers, safety net hospital executives and emergency department directors, local health department officials, consumer advocates, and other knowledgeable market observers.

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the growing population.[19] Although the dental workforce is expected to expand with the development of several new dental schools—with some schools focusing on training students in the community—it is uncertain whether the supply of future dental graduates will meet the rising demand for dental care.[20] Moreover, without incentives for new dentists to treat Medicaid and SCHIP enrollees and low-income uninsured people, it is unlikely that an increased supply of dentists will significantly improve access to dental care for these vulnerable groups. ■

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