

Improving Oral Health Disparities and Access to Care: Challenges and Opportunities for the States

Tim M. Henderson, MSPH

Abstract

States and their dental reimbursement, practice, and education policies and programs have done little to address oral health disparities. Particular state policies and programs are often cited as having an adverse impact on oral health access for vulnerable populations. These include poor Medicaid and State Children's Health Insurance Program reimbursement, an inadequate safety net, the ban on the corporate practice of dentistry, and a lack of funding to prepare the dental workforce to treat special needs populations and provide culturally competent care. (The State Children's Health Insurance Program, created by the Balanced Budget Act of 1997, enacted Title XXI of the Social Security Act and allocated about \$20 billion over five years to help states insure more children.)

While state health officials have paid less attention to oral health disparities, there has been increased interest by state policymakers in addressing the special health care needs

of the elderly, disabled, and children. These include state responses to the 1999 Olmstead Supreme Court decision and state pharmaceutical assistance programs for the elderly and disabled. (In rejecting the state of Georgia's appeal to enforce institutionalization of individuals with disabilities, the Supreme Court in 1999 affirmed the right of individuals with disabilities to live in their community in its 6-3 ruling against the state of Georgia in the case *Olmstead v. L.C. and E.W.*) However, a few states have begun to develop solutions to explicitly address oral health access problems. States are considering or testing the following programs and policies pertaining to 1) improving workforce supply and distribution, 2) education reform and increased public accountability, 3) practice reform, and 4) increased data collection and research.

Author / Tim M. Henderson, MSPH, is an independent health workforce consultant in Fairfax Station, Va.

While the oral health status of Americans overall has improved dramatically in the past 25 years, profound and troubling disparities in oral health remain. Minority, low-income, certain special needs, medically underserved populations, and many rural communities suffer disproportionately from oral pain and disease. Nearly one-third of seniors over age 65 have untreated tooth decay. Similar differences in access to oral health care services exist among these population groups.¹

State Challenges

A 2002 report by the National Conference of State Legislatures for The Robert Wood Johnson Foundation concludes that states and their dental reimbursement, practice and education policies and programs have done little to address oral health disparities.² Interviews with state officials found, not surprisingly, that there is a shortage of dentists who are willing to treat low-income clients, particularly those insured by Medicaid, and children or adults with special health care needs. Many dentists, the report notes, are taught in dental school to refer disabled patients and young children elsewhere, and consequently lack the training and comfort level to treat these populations. Officials in one state noted there is a three-week wait for oral health services for children with special health care needs. Although in another state, a few disabled patients can receive care at a city hospital through the WICHE program (a multistate exchange program that provides slots in professional schools for state residents from states without schools); the impact is seen as minimal. A fiscal analyst at the state legislature said "it would take four years for them to serve the whole disabled population with one dental visit." It

has also been found in many states that much of the oral health workforce has little preparation in providing culturally competent care to racially and ethnically diverse populations.²

Particular conditions and trends in the states are often cited as having an adverse impact on oral health access for vulnerable populations. These include:

- Poor Medicaid and SCHIP reimbursement. In addition to Medicaid and SCHIP, low payment rates that negatively affect dentists' willingness to serve low-income and disadvantaged populations, barriers to access also result when some procedures or

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services receive no reimbursement. For example, coordination or case management between physicians and dentists is rarely funded, though some state children's health officials see the need for it. Also, state Medicaid programs rarely provide extra reimbursement to treat the elderly or people with disabilities, which is particularly challenging considering such patients are seen as more difficult and time-consuming to treat than children.²

- Inadequate safety net. A decaying and inadequate public health infrastructure or safety net for oral health care in most states is a growing concern.²

- Ban on the corporate practice of dentistry. Many states have a ban on the corporate practice of dentistry in their

Dental Practices Act, which prevents dentists from working for any entity other than another dentist. Although such restrictions are often viewed as preserving quality of care, they have been used to prevent the development of dental-managed care and maintain the solo practice model. Such provisions may also erect a legal barrier to the development of public health clinics or the addition of dental services to community health centers in some states unless exceptions are written into law or regulations.²

- Lack of funding to prepare the dental workforce to treat special needs populations and provide culturally competent care. Few, if any, state appropriations for dental education target funding to address these needs, perhaps because of the perception held by some that the dental profession is increasingly focused on providing elective treatment to higher socioeconomic groups.²

The status of these conditions and trends are influenced by the fact that most states have had budget crises in recent years. To lower costs, at least 25 states have reduced or eliminated dental benefits or restricted program eligibility, particularly for adults, under their Medicaid programs. Approximately 37 states have frozen or reduced Medicaid payments to dental providers, causing greater concern over rates of provider participation. Public funding of higher education, including dental training, has been slashed in many states. Consequently, the goal of most state health officials has been simply preservation, rather than expansion, of programs and policies. In general, the National Conference of State Legislatures report concluded that oral health appears to be a low priority for some state health agencies and most state lawmakers. Dental directors in a number of states said they lacked the necessary support from the health commissioner or governor in asking their legislatures for funding for oral health programs.

Moreover, since oral health is a small percentage of overall spending in Medicaid and public health, it typically receives little attention in the policy-making or budgeting processes. In addition, the report found that oral health is not a priority for advocacy groups in the disability or special needs children communities. In two states interviewed, the disability community says that oral health is a “back-burner issue” because access to health care can be a life or death issue.²

State Opportunities

While state health officials have paid less attention to oral health disparities, there has been increased interest by state policymakers in addressing the special health care needs of the elderly, disabled, and children without regard explicitly to oral health care.

Response to Olmstead

Long before the 1999 Olmstead Supreme Court decision, states were increasingly providing home and community-based services for the elderly and disabled, primarily through Medicaid waiver programs. However, Olmstead, along with federal grants, have spurred state and local activity and have kept the momentum alive for serving qualified individuals with disabilities in the most integrated setting. According to a February 2004 report by the National Conference of State Legislatures, 29 states had issued an Olmstead-related plan or report as of the end of 2003. The plans identify a strong community-based system as one in which consumers have a variety of options tailored to their individual needs.³

Although the budget crises have constrained the more costly Olmstead plan recommendations, the states were able to implement some of the low-cost or cost-neutral solutions, especially those receiving federal grant support, such as consumer-directed care; efforts to move

people back into the community or divert institutional placement; and consumer outreach and education. In at least nine states, worker wages have increased, background checks are required, or new curriculums or training to address severe workforce shortages have been created. There are high turnover rates of paraprofessional workers such as nursing assistants, home health aides and personal care attendants, who provide the bulk of hands-on care that many people with disabilities need in order to remain at home or in community-like environments. This direct care worker shortage results from low wages, nonexistent or poor benefits, limited advancement

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opportunities, and lack of respect for the important services they provide.³

Pharmaceutical Assistance Programs

As of September 2004, at least 39 states have established or authorized some type of program to provide pharmaceutical coverage or assistance, primarily to low-income elderly or persons with disabilities who do not qualify for Medicaid. Most programs utilize state funds to subsidize a portion of the costs, usually for a defined population that meets enrollment criteria, but an increasing number use discounts or bulk purchasing approaches. The availability of tobacco settlement funds has been a substantial factor in stimulating discussion and legislative activity relating to prescription drug subsidies.⁴

State Children's Health Insurance Program

Enactment of the State Children's Health Insurance Program in the late 1990s gave states a unique opportunity to effect change for low-income, uninsured children with special health care needs. States can use the flexibility of SCHIP to grapple with design issues to improve services for children with special health care needs. Strategies include providing supplemental benefits, arranging for specialists to be included under the SCHIP plan, expanding eligibility criteria to assist additional families, defining “medical necessity” more broadly, modifying cost-sharing requirements, and addressing quality assurance issues.

In addition, a few states, with a greater awareness and concern of oral health disparities, and in some cases, an improved budget climate in the past two years, have begun to develop solutions to address oral health access problems. Some states have implemented or are considering testing the following programs and policies:

Improving Workforce Supply and Distribution

- Create and target dental/dental hygiene and public health career promotion activities to junior high and high school students from underrepresented populations in underserved and diverse communities.

- Revise dental/dental hygiene school admission requirements to favor admitting an increased complement of students interested in community/public service and students from medically underserved areas and underrepresented minority populations. Encourage or require dentists/hygienists from medically underserved areas/underrepresented minority populations to serve on school admissions committees.

- Create/expand the availability of

financial incentives for community service for dental/dental hygiene students, particularly those from underserved and underrepresented populations. Incentives include tuition reimbursement, educational scholarships, debt/loan forgiveness programs, and federal traineeships.

- Create pilot projects to encourage licensure of qualified foreign-trained dentists. California enacted legislation to start a pilot project to bring dentists from Mexico to underserved areas of California, and to require that the California Dental Board visit and certify foreign dental schools so graduates of those schools can take the California license examination.

Education Reform

- Identify and diffuse a model core curricula in community/public service for publicly funded dental and dental hygiene schools, including the creation of:

- A strong complement of coursework in community/population health and disease management, cultural competence, needs of special groups, public health and health services research, program planning and evaluation, and public policy, and

- More service-based education opportunities in low-income and racially/ethnically diverse community-based settings, perhaps requiring such rotations to be a condition of graduation.

- Encourage existing schools to develop/expand satellite campus training programs in community-based, underserved areas.

- Engage area health education centers to involve/support more dental health professionals in community-based education and projects.

- Promote/fund the creation of a “year of service learning” postgraduate residency in a variety of public health or underserved community-based settings, initially as an elective and later

as a requirement. Apply what has been learned from New York and other states, Mexico and other countries, as well as other programs that have a fifth year of service. Provide nonprofit providers (e.g., community health clinics) the needed funds to hire dentists to provide supervision for dental students and graduates doing such residencies and externships.

- Identify practical means for integrating oral health into other health professions education, such as medicine and nursing. There is growing interest in North Carolina and other states to develop programs to train pediatricians to do screening for oral health problems

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in the newborn to age 3 population and collaborate with dentists regarding treatment. Similarly, a few states are interested in funding public dental schools that will also provide training for physicians, nurse practitioners and physician assistants in oral health screenings and the application of fluoride varnishes.

Practice Reform

- Evaluate innovative approaches for providing services in underserved areas and for minority populations, such as the New Zealand dental nurse program and the Alaska health technician or community health worker program.

- Create authorization for pri-

mary care physicians/nurse practitioners to provide certain preventive oral health services, particularly in public health/low-income settings. Provide financial incentives (e.g., tax credits) for dentists to collaborate with them in this capacity.

- Provide incentives (e.g., license/malpractice insurance subsidies, special licensing, and malpractice immunity) for retired dental professionals to provide voluntary care at least on a part-time basis, particularly in public health/low-income settings. Minnesota’s Legislature created a program to reimburse retired dentists for the cost of license renewal and malpractice insurance if they perform 100 hours of volunteer dentistry annually. Similar initiatives have been enacted in other states, and may be modeled after programs funded by Volunteers in Health Care.

- Through legislation or regulation, design, demonstrate, and evaluate the impact of various new dental practice alternatives that better address community/population health and disease management, particularly for low-income and underrepresented populations. Some states have sought seed money to establish or support “model practices” and demonstration programs to improve access, such as a non-entitlement adult dental care program or a dental HMO that uses evidence-based practices, focuses on prevention, and evaluates outcomes.

- Expand the number of model stationary and mobile public dental clinics operating in underserved communities. Provide greater financial and other incentives for recruiting and retaining dentists/hygienists to work in such settings, e.g., tax credits, grants via tobacco settlement/tax funds, loan repayment, travel/lodging discounts, practice management/cultural competence training and technical assistance, continuing education, and donation of clinical/business equipment.

■ Create more incentives for dentist participation in Medicaid/SCHIP by states paying at market levels and offering volume-based fee incentives. Other funds could be made available to improve outreach to dentists to become Medicaid/SCHIP providers and to provide incentives for dentists who treat disabled and low-income, high-need patients.

Increased Data and Research

■ Develop a new oral health data collection and research agenda to address issues associated with populations with special health care needs in dental education and practice, as well as in government and public policy. For state policy officials in particular, there is a need for more data on the nature and extent of current access problems and for research, evaluation or policy analyses on financing or program models to fix access problems. A number of state oral health officials want more current and detailed information about the prevalence of oral health problems and unmet needs among different populations, not only to spur policy and program development but to develop realistic cost projections of new dental benefits in Medicaid and SCHIP. For example, research is needed to determine the cost of hospital dental care for disabled patients for care that could be delivered in a dental office if qualified dentists were available. Disability advocates might want information about the impact of untreated dental problems and poor oral health on employability. Participation in such data collection and research by the dental profession is important to improving understanding of populations with special health care needs.

• Increase federal and state government funding for disability-based oral health data collection and research. Promote and justify the evidence and need for the new research agenda.

• Inform policymakers and agency administrators of the results of applied disability-based oral health/health services research for their constituents. Translating evidence-based research into policy and program decision making is a key activity to realizing the value of such study.

• Incorporate new research findings on disability-based dental health/health services research into school curriculum and practice guidelines. If the research findings are to have any lasting impact on dental care, they must become integrated into the education of future dental health professionals.

Greater Public Accountability

As evident by their long history of financial support, many states believe dental education to be a public good. That is, they believe it to be a good or service that benefits the public at large and will not be produced at the appropriate level in the private market because of difficulty in pricing it. Although the community at large, including future patients and dentists, benefits from dental education, it is impossible to charge future beneficiaries. If left to itself, the private market is likely to “underproduce” dental education. Managed care and other private health plans do little to invest support for dental education. Moreover, the costs of training are too great for many dentist trainees to pay entirely without incurring large debts.

In an era of tight state budgets, states should be prepared to address the following questions in deciding how to continue their support for dental education (much like many states have done for medical education):

■ What does the state want from its dental school?

■ How effective are state-supported dental schools in preparing dentists to meet public needs?

■ How can states improve the chances that their state-supported den-

tal schools will prepare dentists to meet public needs?

Conclusion

Several new ideas and initiatives by states hold promise in improving access to oral health care for special needs and other vulnerable populations. Given shifting state fiscal capacities and policy priorities, oral health advocates must be prepared to develop collaborative partnerships with other advocates of vulnerable and special needs populations to ensure that oral health access is improved. CDA

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To request a printed copy of this article, please contact / Tim M. Henderson, MSPH, 11838 Clara Way, Fairfax Station, Va., 22039.