



American Dental Association
www.ada.org

American Dental Association

▶ STATE AND COMMUNITY MODELS FOR IMPROVING ACCESS TO DENTAL CARE FOR THE UNDERSERVED

October 2004

Executive Summary

American Dental Association. *State and Community Models for Improving Access to Dental Care For the Underserved—A White Paper*. Chicago: American Dental Association: October 2004.

To obtain a complete copy of *State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper*, go to www.ada.org or e-mail access@ada.org.

Copyright © 2004 American Dental Association.

Permission is hereby granted to copy and distribute all or any portion of this work solely for noncommercial purposes, provided that you prominently display this copyright notice on each copy of the work.

▶ VISION STATEMENT

With each passing year, science uncovers more evidence of the critical importance of oral health to overall health. Early diagnosis, preventive treatments and early intervention can prevent or halt the progress of most oral diseases-conditions that, when left untreated, can have painful, disfiguring and lasting negative health consequences. Yet millions of American children and adults lack regular access to routine dental care, and many of them suffer needlessly with disease that inevitably results. Oral health access problems cut across economic, geographic and ethnographic lines. Racial and ethnic minorities, people with disabilities, and those from low-income families are especially hard hit.

The nation's dentists have long sought to stem and turn the tide of untreated disease, as individuals, through their local, state and national dental societies, and through other community organizations. Dentists alone cannot bring about the profound change needed to correct the gross disparities in access to oral health care. But dentistry must provide the leadership that initiates change, or it will not occur.

Ultimately, education and prevention will be the linchpins in eliminating, or at least minimizing, untreated dental disease. The day that we as a nation decide to provide oral health education to families of newborns, public health measures such as community water fluoridation, and regular dental visits to every American will mark the birth of the first generation that could grow up essentially free of dental disease. Until that occurs, the nation will be challenged to meet the needs for preventive and restorative care among large numbers of Americans who do not have dental coverage, cannot afford care or face other challenges that prohibit them from seeking regular oral care and dental visits.

The American Dental Association and its members will continue working with policymakers to establish programs and services that improve access to oral health care. We urge the nation to join us in:

- ▶ Rejecting programs and policies that marginalize oral health, and instead supporting those that recognize that oral health is integral to overall health and can affect a person's self esteem, ability to learn and employability.
- ▶ Acknowledging that the degree of oral health disparities and the extent and severity of untreated dental disease-especially among underserved children-is unacceptable.
- ▶ Committing, through both advocacy and direct action, to identify and implement commonsense, market-based solutions that capitalize on the inherent strengths of the American dental care system and that make it possible for all Americans, regardless of their financial, geographic, physical or other special circumstances, to experience optimal oral health care.

▶ EXECUTIVE SUMMARY

BACKGROUND: Oral health means much more than healthy teeth and gums. It is integral to overall health, self-esteem, ability to learn and employability. The 2004 white paper *State and Community Models for Improving Access to Dental Care for the Underserved* is the latest in a series of ADA publications, programs, symposia and other initiatives aimed at state and federal policymakers, the public health community, the media, other opinion leaders, the dental profession and the general public about the extent of unmet need for dental care among large groups of Americans. The poor—including low-income elderly—the disabled and residents of those rural and inner city areas where attracting a dentist is difficult, are particularly hard hit.

Dentists provide billions of dollars in charitable education, screening, preventive and restorative services, both as individuals and through their local, state and national professional societies. But charity care alone—even of this scope—is not a long-term solution to making oral health care accessible to the millions of Americans who do not get it.

BARRIERS TO CARE: Federal law requires states to cover dental benefits for Medicaid eligible children. All states except Texas and Delaware also provide dental services to children eligible for the State Children's Health Insurance Program. But with a few exceptions, these programs—typically underfunded and poorly administered—provide dental services to only a small percentage of those eligible. Access to dental care for low-income and disabled adults is exponentially worse, with few public assistance programs providing adequate coverage.

- ▶ Medicaid reimbursement rates are often so anemic, and administrative burdens so onerous, as to discourage provider participation. In many cases, reimbursement rates fail to cover even dentists' overhead costs in providing care.
- ▶ Even when care is available, programs often fail to provide the case management services needed to help people get to dental appointments and comply with post-treatment instructions and oral hygiene protocols.
- ▶ Low levels of oral health literacy lead to often-severe dental disease that could otherwise be prevented cheaply and easily.
- ▶ Economic conditions discourage dentists from practicing in some inner city and rural areas, creating location-specific dentist shortages.

MARKET-BASED SOLUTIONS: Working with other stakeholders, the ADA has researched extensively the problems plaguing dental public assistance programs and the innovations under way in some states and localities to address them. This paper examines five models, three at the state level and two at the community level, which other states and communities could adopt, modifying them as appropriate to meet the specific needs of their residents.

1) Michigan's Healthy Kids Dental Medicaid demonstration program is a partnership between a state Medicaid program and a commercial dental plan, with the plan managing the dental benefit according to the same standard procedures and payment mechanisms it uses in its private plans. The proportion of Medicaid eligible children who saw a dentist at least once increased from 32 percent to 44 percent in the pilot program's first year. This model demonstrates how contracting with a single commercial entity that 1) has a strong existing dental network, 2) offers competitive market-based reimbursement and 3) streamlines administration to mirror the private sector can substantially improve access to care for Medicaid beneficiaries.

2) Tennessee's TennCare program was the first attempt by a state to move its entire Medicaid population into a statewide managed-care system. The impact on dental services was disastrous. The number of participating providers dwindled from its 1984 level of more than 1,700 to 386 general and specialist dentists available to treat the more than 600,000 TennCare eligible children. In 2002, the legislature enacted a statutory carve-out of dental services, which mandated a contract arrangement between the state and a private dental carrier to administer benefits for children (under age 21). The state retained control of reimbursement rates and increased them to market-based levels.

The new rate structure, in combination with administrative reforms, patient case management strategies and a requirement that the carrier maintain an adequate provider network, has substantially improved TennCare's provision of dental services. In just two years, the utilization rate among eligible beneficiaries has increased from 24 percent to 47 percent (Private sector utilization ranges from 50 percent to 60 percent). As of June 2004, about 700 dentists were participating in the program, with 86 percent of participants accepting new patients.

3) Alabama reformed its state-administered dental Medicaid program in 2000 to reimburse dentists at rates equivalent to those paid by commercial insurers. (The program still reimburses dentists at year 2000 rates.) The changes included creation of the Smile Alabama! initiative, which encompassed administrative reforms, a case management program, and increased outreach to both patients and dentists. The number of participating dentists has increased 47 percent, from 441 in 1999 to 674 in June 2004. The increased workforce resulted in increased utilization—26 percent of eligible children saw a dentist in 1999; in 2003 39 percent of eligible children had at least one dental visit.

4) The Connecticut Health Foundation has been a leader in exploring contracting between federally qualified health centers (or similar public health clinics) and private practice dentists to provide care to underserved patients. Under these contracts, the health centers and dentists negotiate the types and amount of services to be provided. Dentists do not need to be Medicaid providers to treat Medicaid patients—the health centers are responsible for billing Medicaid for the services.

5) In Brattleboro, Vt., Head Start, the state health department, school officials and hospital administrators collaborated to establish a fee-for-service, for-profit dental center to address the needs of the underserved in a rural community. The practice serves both private paying and public assistance patients and pays a percentage of non-Medicaid revenues to the non-profit contracting entity (the community partners). In its first two years of operation, the clinic has cleared a huge backlog of children with acute and chronic dental needs and has begun to increase adult utilization as well.

The models in this white paper exemplify innovative ideas that could help other states and communities increase access to critically needed oral health services for their underserved populations. They were selected based on suggestions from state policymakers, public health representatives, state dental directors, the dental insurance industry and private-practice dentists. They reflect the consensus among these stakeholders that only through public-private collaborations will the nation make substantive progress in improving access to care for the underserved.

Ultimately, the success of these models will hinge on the quality of individual programs—financing, administrative processes and case management services, and their success in recruiting participating dentists. Their promise is that they are designed and implemented by the states or communities they will serve, allowing them to work toward meeting local needs according to local resources. Local and state dental societies stand ready to explore these collaborative models with community leaders for the improvement of the oral health of the American public.