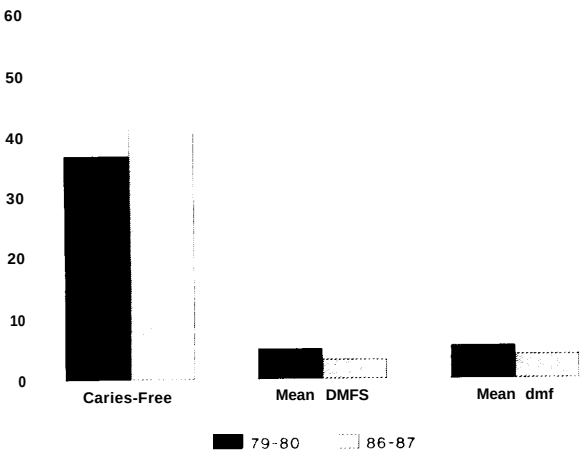
Chapter 1
Summary

Introduction

The oral health of the Nation's children has been improving steadily for over 10 years. Since 1979, the number of children with no caries has increased, the average number of decayed teeth per child has shrunk, the average number of filled teeth per child has increased, and each child averages fewer missing teeth (18) (see figure 1). While these numbers suggest that, on average, fewer teeth are decayed in the first place, they also reflect changes in utlization—more decayed teeth are filled and fewer teeth are extracted as a result of decay.

But some children have not experienced this oral health phenomenon with the same intensity as others their age. Specifically, nonwhite school children (ages 5 to 17) average fewer filled teeth and more missing teeth due to decay than white school children, though their average numbers of decayed teeth do not differsignitlcantly(18) (see figure 2). In addition, data on periodontal conditions (e.g., gingival bleeding and periodontal attachment loss) reflect a similar pattern, where fewer white children (ages 14 to 17) experience problems than nonwhite children (3,4) (see figure 3).

Figure l-Changes in Caries Experience in U.S. School Children, Ages 5 to 17,1979-80 and 1986-87



NOTE: DMFS refers to the mean number per person of decayed (D), missing (M), and filled (F) surfaces of permanent teeth; dmf refers to the mean number per person of decayed (d), missing (m), and filled (f) primary teeth.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental Research, *Oral Health of United States Children: The* National *Survey of Dental* Caries *in U.S. School Children, 1966-87,* NIH publication no. *89-2247* (Washington, DC: U.S. Government Printing Office, September 1989).

National data are collected only by age and race (white or nonwhite) of school children. Though it would appear from the data that the dental treatment needs of nonwhite children are not being met, other factors, such as socioeconomic status, may more accurately describe children dental treatment needs and their use of dental services.[1]

Most children below the Federal poverty level receive dental care through the Medicaid program, principally through its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (Social Security Amendments of 1967, Public Law 90-248).[2] EPSDT is a comprehensive health care program, including a dental component, for eligible children.[3] In some States, the only Medicaid eligibles that are provided preventive and therapeutic dental care are those children enrolled in the EPSDT program (l), since the benefit is required for the State to receive Federal funds.

Findings and Conclusions

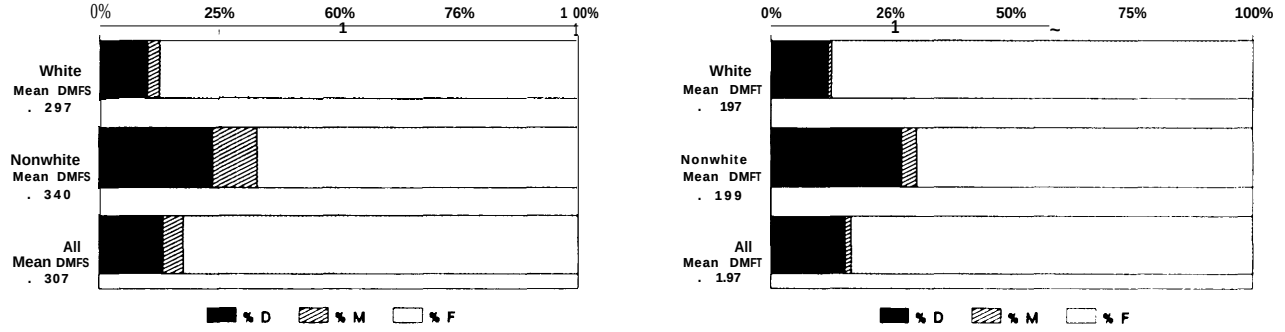
OTA was asked by the House Energy and Commerce Committee and its Subcommittee on Health and the Environment to ascertain whether the dental care programs for Medicaid beneficiaries, particularly children eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, conform to a minimum standard of dental care and, if possible, to include some measure of the actual dental care received under the State programs.

[1] For example, family income and dental insurance coverage are associated with the utilization of dental services (6,7). Although the data do not directly link socioeconomic status and race, children from low-income families and minority children (ages 12 to 17) are less likely to be covered by private dental insurance than are children from higher income families and white children (15), and therefore, less likely to receive dental services.

[2] Ch. 3 describes the Medicaid program and its EPSDT component more fully.

[3] Authorized by Congress in 1967, regulations implementing the EPSDT program did not take effect until 1972, and specific dental guidelines were not introduced until 1980 (19).

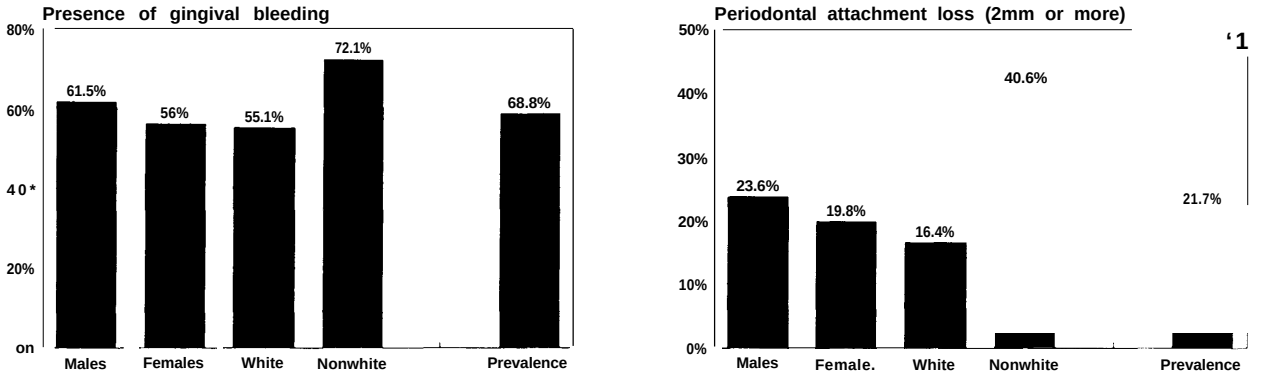
Figure 2—Percent of DMFS[a] and DMFT[b] Due to Deeayed, Missing, and Filled Surfaces and Teeth, 198&87



[a]DMFS refers to the mean number per person of decayed (D), missing *(M),* and filled (F) permanent teeth.
[b]DMFT refers t. the mean number per person of decayed (D), missing (M), and filled (F) surfaces of permanent teeth.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental Research, *Oral Health of United States Children: The National Survey of Dental Caries in U.S. School Children, 1986-87,* NIH publication no. S9-2247 (Washington, DC: U.S. Government Printing Office, September 1989).

Figure 3-Periodontal Status of U.S. School Children, Ages 14 to 17, 1986-87



SOURCES: M. Bhat, "Periodontal Attachment Loss in 14-to 17-Year-Old U.S. School Children." Program and Abstracts. American Association for Public Health Dentistry, November 1989; M. Bhat, and J. Brunelle, "Gingival Status of 14- to I?-Year-Old U.S. School Children," *Journal of Dental Research* 68:955, June 1989.

This study looks at the dental care component of Medicaid programs (including dental care provided under EPSDT programs) in a sample of seven States to answer whether "basic" dental services[4] are provided and whether programs impose barriers that restrict eligible children's access to these services. Briefly, the study found in the States sampled that:

- there are significant differences among these States in the dental services offered through their Medicaid programs;
- each of these programs failed (in varying degrees) to adequately cover "basic" dental services in their Medicaid program (specifically, though some services are universally provided-particularly initial visits, x-rays, and restorations, newer technologies (e.g., sealants) and many basic therapeutic services (including periodontal, prosthetic, and ortho-

[4]App. A lists these "basic" services, and the method of study (ch. 2) describes how they were identified.

dontic services) are generally not covered, or are of limited availability);[5]

- there are some services that some dentists feel they do not equally provide to their young Medicaid patients under 18 compared to their other young patients; and
- a variety of barriers, identified by both State representatives and private practice dentists, restrict the low-income child's access to dental services under State Medicaid programs (e.g., low reimbursement rates for dental services rendered under Medicaid may restrain provider participation in the program).

The scope of this study is purposely narrow, focusing on only a small part of the health care system and only a handful of the population it serves. Yet, the study raises some disturbing questions about this system and the priority it gives to oral health of low-income children. Although States are ultimately responsible for defining their package of dental services for children, Federal regulations specify the provision of certain services. Nonetheless, some of these required dental services are not available to children under Medicaid. Also, it is not clear that any Federal action has been taken to ensure the inclusion of these dental services. This raises concerns about the accountability of State programs and also about Federal enforcement of its own policies and regulations.

Not unrelated, the priority of oral health care within the Federal health care system is questionable-Medicaid spends less than 1 percent of its payments on dental care, for both adults and children. Although this study did not critique the effectiveness of these basic dental services or their costs, the inevitable next questions are: given that some basic dental services are not routinely available to low-income children, what are the oral health and other impacts on these children and what are the short- and long-term costs for the public health care system?

[5]Table 1 summarizes and app. C specifically reports the comparison between the compiled list of basic services and the State Medicaid manuals.

Table l-Major Differences Between the List of Core Components and State Medicaid Manuals

Selected Services	Major Difference, by State
Preventive	
• periodic exam	CA: Only for developmentally disabled children TX: No billable procedure code for periodic exam
• prophylaxis	TX: For patients 13 to 20 years, this procedure is intended for periodontal cases only.
• fluoride treatment	Tx: Is included in fee or proph ylaxis, is not required, and is not billable separately.
• counseling on self care	ALL: No State specifica ly requ red that these services be prov ided. One State (MI) specifically excluded separate payment for oral hygiene instruction.
• sealants	CA: Not specified MI: Not specified TX: Not specified MS: Allowed for newly erupted first and second permanent molars or first and second premolars. Prior approval required for primary teeth. " NV: One sealant per primary tooth (ages 6-20). OH: Ages < 9: permanent first molars Ages < 15: permanent second molars One application per tooth per lifetime
• space maintenance	CA: Space maintainers are allowed "where there is sufficient roan for an unerupted permanent tooth to erupt normally." It is not covered to hold space for missing permanent teeth. MI: Space maintenance requires prior authorization, and is limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth. NV: Prior authorization is required--not a routinely available benefit. TX: Limited to loss of primary second molar.
Therapeutic	
• restorations	
-amalgam	ALL: No major differences
-other	CA: For silicate, composite, and plastic restorations, but only on anterior teeth MI: For silicate, composite, and plastic restorations, but only on anterior teeth MS: Composites may be performed on both anterior and posterior teeth, primary and permanent NV: Acry(ic/plastic and composite resin, but only on anterior teeth NY: For anterior teeth only OH: For anterior teeth only TX: Higher fee for anterior teeth than posterior teeth
• pulp therapy	CA: Included in restoration fee MI: Direct pulp cap is covered, not indirect pulp cap MS: No billable procedure code NY: Not covered OH: incIded in restoration fee Tx: No billable procedure code

• pulpotomy	CA: Therapeutic pulpotomy for deciduous teeth only. Vital pulpotomy for vital permanent teeth only. MI: Vital pulpotomy is covered for deciduous teeth, and for vital permanent teeth with incompletely formed roots. Requires prior authorization. MS: Pulpotomy for primary teeth does not require prior authorization. TX: Therapeutic pulpotomy with base.
• root canal	CA: Limited benefit for posterior and anterior permanent teeth through age 17. MI: Prior authorization is required for any root canal therapy. MS: Root canals for permanent teeth require submission of substantiating x rays. NV: Prior authorization required--not routinely available benefit. OH: Allowed only on permanent teeth. TX: Limited to four permanet teeth for each recipient, x-rays required. NY: Prior authorization is required for three or more canals.
• periodontal scaling and root planing	CA: Periodontal services are limited to beneficiaries 18 and over. MI: Requires prior authorization. MS: Not covered. NV: Not covered. OH: Could be provided as part of prophylaxis, if necessary. no separate billable procedure code. TX: Fee for prophylaxis for ages 3-12 includes subgingival scaling, but neither periodontal scaling and root planing nor gingival curettage are specifically covered services.
• gingival curettage	MI: Requires prior authorization. MS: Gingival curettage will be considered only for patients on Dilantin therapy. NV: Prior authorization required, not a routinely available benefit. NY: Not covered (but gingivectomy and gingivoplasty is allowed. OH: Not covered (but gingivectomy and gingivoplasty sometimes--not often--allowed with prior authorization). TX: Not covered.
• removable prosthesis	CA: Limited benefit (e.g., only when necessary for the balance of a complete denture) once every 5 years. MI: Authorized only if one or more incisor is missing or fewer than 6 teeth are in occlusion in posterior areas. MS: Prior authorization is required. NV: Prior authorization required--not a routinely available benefit. NY: Prior approval is required. OH: Prior authorization required. TX: May be authorized if the recipient has missing anterior teeth or less than 8 occluding posterior teeth (age 9-20).
• orthodontic treatment	CA: Orthodontic treatment is limited to beneficiaries with cleft palate deformities who are under case management of the California Children Services Program. MI: Orthodontic procedures are only provided to children medically eligible for the Crippled Children Program (Medicaid recipients are already financially eligible) and require prior authorization. MS: For permanent dentition only, and must receive prior approval. NV: Orthodontics available only to beneficiaries eligible for Crippled Children Program. NY: Prior authorization required. OH: Orthodontic coverage is limited to only those children with the most severe handicapping conditions. TX: Orthodontic coverage is limited but may be authorized for children with the most severe handicapping conditions.

NOTE: The Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) included prior authorization as a mechanism to ensure medical necessity, but maintained that the controls must be consistent with the "preventive thrust of the EPSDT benefit." Services that are allowed only if prior authorized are included in this table.

SOURCE: Compiled from State Medicaid manuals by the Office of Technology Assessment, 1990.