Chapter 4
Barriers to Dental Care Under Medicaid and EPSDT

This study concerns the dental care that States provide for under Medicaid, rather than the care that may or may not be delivered through the program. However, during the course of the study, many expressed the opinion that the major problem may not be the absence of dental services in State manuals, but the lack of dental care that is actually received. In other words, various barriers block access to the dental care that low-income children should receive under States' Medicaid programs.

On September 22, 1989, OTA invited representatives from each of the States in the study sample and other representatives from the public sector and interested professional associations to identify some of these barriers to access to dental care (see app. B for a list of participants). The section below outlines some of the opinions expressed by the workshop participants; this list should be considered neither exhaustive nor representative of in-depth analyses. These brief descriptions attempt to capture some of the more descriptive details, but what is clear is that further study is necessary to identify, describe, and eliminate the major deterrents to good oral health among low-income children. Some examples of further study include the relationship of Medicaid fees to those of the real world and costs of operating a dental practice, and a descriptive study of the types of dental services provided through EPSDT, viewing it as a health care delivery system.

In January 1990, OTA surveyed a sampling of private practice dentists in each of the seven States in the study, which included nearly 4,500 dentists.[1] In three parts, the survey asked the dentists about: 1) themselves (e.g., age, race, specialty, whether they participate in the Medicaid program, whether they treat children, etc.), 2) their opinions about the Medicaid program in their State (e.g., reimbursement issues, administrative issues, and scope and limitations of covered services), and 3) about their provision of certain services (those in app. A) to children under Medicaid.[2] The dentists' responses to the second and third sections identify aspects of the Medicaid program that could be viewed as barriers to children's access to dental care. Some of their responses echoed the opinions expressed by the participants in the workshop.

Barriers Identified at the Workshop

The barriers, as discussed at the workshop, are conveniently arranged below by topic, but are complexly intercomected in real life. This simplistic approach and the lack of detail should not imply that these problems are insignificant or small, only that they have not been evaluated by OTA. Also, although some topics seemed to be more fervently emphasized during the workshop than others, the order below is not based on any judgment of importance. Since the purpose of the workshop did not include reaching consensus, not all the topics described below were expressed by every participant.

Topic: Structure of the Program—Medicaid and/or EPSDT

Several types of structural problems were identified during the workshop, such as problems with personnel, guidance, reporting requirements, quality control, and eligibility requirements.

Personnel issues were generally about training: e.g., that dental department consultants are usually private practitioners rather than public health dentists, or that some welfare departments lack dental expertise, or that inexperienced nondental providers may control access to dental care under EPSDT. Other personnel issues focused on process: e.g., that State Medicaid offices and State dental directors may not communicate well, or that a rivalry exists between some State Medicaid agencies and public health agencies, or that the State Medicaid office could cooperate more closely with State licensing boards.

The label ''guidance" represents a diverse set of problems. There was an opinion that guidance on a national level is missing: that the goals and expectations of the program have dropped since its inception, as signified by the small percentage of the

[1]The sample represented 10 percent of the dentists in California, Michigan, New York, Ohio, and Texas and 20 percent of the dentists in Nevada and Mississippi.

[2]The survey instrument is provided in app. D.

Medicaid budget spent on dental care, in spite of evidence that these children have significant levels of untreated dental disease (18); and that HCFA regulations should be more clear and that standards of dental care should be addressed. The results of the lack of national guidance were expressed as a lack of definition and consistency of available services, and the inability or unwillingness of States to pay for the services. There was also concern that there may be increasing reliance on the program as the only source of care by people who are least able to influence change in the program.

Some participants felt that the lack of reliable and comparable data was a barrier to evaluating the program directly, and indirectly affected the quality of care received by its beneficiaries. Quality control as an issue itself was discussed during the workshop; some observed that ''Medicaid Mills,' or the practice of a sole provider or clinic treating very large numbers of Medicaid beneficiaries, posed questions about the quality of care received within their programs. Also, although Medicaid is the largest publicly funded dental program in the Nation, many States have no mechanism in place for monitoring the quality of dental care received by recipients.

Lastly, some felt that another barrier restricting the use of dental services for low-income children was the Medicaid eligibility requirements for their program.

Topic: Competition for Resources

Some participants suggested that the lack of data about the oral health status of eligible children and the adequacy of the program lead to policies, that, in effect, lower the priority for the dental component of Medicaid programs, losing the competition for scarce State resources.

Topic: Low Provider Participation

A recurring observation throughout the workshop was the universally low dental provider participation rates in the programs. Fewer providers provide services to fewer Medicaid beneficiaries, significantly lowering the accessibility of these dental services. The services of specialists, such as periodontists and pediatric dentists, are also rarely provided to children under Medicaid. The issue of low participation is a prime example of the interrelated nature of these problems; many felt that low fees and administrative burdens characterizing the programs were the primary influences resulting in low provider participation. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Low Fees/Reimbursement Issues

Though not all participants felt that low fees were a primary problem in their State, most felt it was significant; some fee levels were described as far below the usual charges for services, others as not even covering average overhead costs. In addition to the impact of low fees on the accessibility of services (noted above), there was concern that inadequate fees may encourage inadequate treatment. Many participants were concerned about small, untimely, or nonexistent fee increases for dental services and the incomparability of fees for dental services in relation to other types of services under Medicaid. Other reimbursement issues, such as late payments or payment denials, are discussed below among other administrative paperwork issues. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Paperwork Burden

Problems with paperwork were said to provide an additional disincentive for dentists to participate in the programs. In particular, three types of problems were discussed: problems with filing claims, slow payment, and denial; problems with prior authorization requirements; and problems with the fiscal intermediary or Medicaid agency. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Perception of Program by Dental Professionals

One participant noted that once providers leave the program, they rarely reenter it. The unfavorable perception of the program among those in the profession certainly has an impact on current participation rates, and may continue to influence future providers. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Transportation

Although some allowance is provided for transportation in the HCFA regulations for EPSDT, some participants felt that it remained a problem for some recipients and resulted in missed appointments or failure even to schedule one.

Topic: Recipients

The recipients themselves may limit the dental services they receive under Medicaid. For whatever reasons, many of those who are eligible never use their dental benefits. Some workshop participants were concerned about the awareness of some Medicaid-eligible children (or their parents) about the dental services offered by their program (discussed below).

The providers' perception of the Medicaid patient also seemed to be a problem; "missed appointments," "poor compliance and difficult to treat," ''negative impact on private-pay patients' describe some provider perceptions mentioned at the workshop.

Topic: Recipients' Awareness of Program

As noted before, several participants were concerned that recipients were not being 'reached' and made aware of their dental benefits or how to access them (who could treat them or that transportation may be available).

Topic: Recipients' Perceptions About Dentistry in General

Perhaps another cause of low dental benefit use by those eligible is, as noted by one participant, due to a widespread negative attitude about dentistry and dentists, which is often related to prior experiences of adult family members. The importance of the educational component (both the child and their parent) of treatment should be emphasized due to recipients' lack of knowledge about the benefits of modern dental care, according to another participant.

Topic: State-Specific Barriers

Some participants felt that service limitations, particularly the lack of effective provision of basic services (e.g., those services listed in app. A), have varying degrees of negative effect on oral health in certain States (see below and app. D for supporting information from OTA's survey of dentists), Another barrier to improving oral health with minimal public expenditure was felt to be the lack of community water fluoridation for 45 percent of the U.S. population (5).

Barriers Identified in Survey of Dentists

Since State Medicaid programs can be very different, the surveyed dentists' responses were grouped by State. The second section of the survey asked the dentists their opinions about the Medicaid program in their State. Detailed figures in appendix D present their responses by State and by their participation in the Medicaid program. In general, those who do not participate in the Medicaid program appeared to have a more negative opinion about the program. Although responses varied by State, some aspects of Medicaid programs—reimbursement level, timeliness of payment, the criteria on which payment or denial of claims are based, prior authorization process, and conformity with community standards of practice-were often rated poorly by the surveyed dentists.

The third section of the survey asked dentists[3] about the provision of certain services to children under Medicaid. Again, responses varied by service and by State. Dentists were asked:

- Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under age 18?
- For each service you responded 'no' to above, please indicate any or all of the possible reasons (i.e., a) service not covered, b) service is not allowed frequently enough, c) benefit excludes use of appropriate materials, d) circumstances allowing service are too narrow, and e) prior authorization is difficult to obtain).
- For each service, do you feel that any other difficulties significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients (responses: g) no; h) yes, Medicaid reimbursement for this service is insufficient; i) yes, the administrative process for this service is particularly burdensome; j) yes, Medicaid requirements regarding this service were not clearly communicated)?
- For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

According to some dentists, the Medicaid program did not adequately allow some services they

[3]This section waa directed only to those dentists who both participate in the Medicaid program and treat children under age 18.

felt were necessary to Medicaid patients, particularly counseling children and parents on self care, sealants, pulp therapy for permanent teeth, periodontal scaling and root planing, ginigival curettage, removable prostheses, and orthodontic treatment. Their reasons are very mixed and are presented in appendix D, but very often insufficient reimbursement was one reason that significantly compounded the problem of providing that sex-vice.

These same services, many dentists felt, were not received by young Medicaid patients with the same intensity as their other young patients.

Problems cited by dentists are often reflected in the State Medicaid manuals, e.g., many dentists in Texas felt that children under Medicaid did not receive topical fluoride treatments with the same intensity as their other patients and, in fact, the State does not cover that service for older children.