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. 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. 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 interconnected 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

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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, signifi-
cantly lowering the accessibility of these dental
services. The services of specialists, such as period-
dontists and pediatric dentists, are also rarely
provided to children under Medicaid. The issue of
low participation is a prime example of the interre-
lated 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
ever 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 authoriza-
tion 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 partic-
ipation 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 trans-
portation 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.
Chapter 4—Barriers to Dental Care Under Medicaid and EPSDT

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).
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, gingival 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 service.

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.