

# Children's Dental Health Improvement Act Pro/Con Analysis

For the Health District of Northern Larimer County Board of Directors

April 24, 2007

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**Bill Title:** Children's Dental Health Improvement Act of 2007

**Issue Summary:**

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## Bill Summary

The Children's Dental Health Improvement Act of 2007 aims to improve the delivery of dental services to low-income children under Medicaid and the State Children's Health Insurance Program (SCHIP). H.R. 1781 was introduced in the US House of Representatives by Representative Dingell and Representative Simpson and the Senate companion bill S.739 was introduced in the US Senate by Senator Bingaman. The goal of the Children's Dental Health Improvement Act is to improve access to dentists and to improve reporting and tracking of data regarding dental disease among children. There are four pieces to this legislation.

### 1) Improving Delivery of Pediatric Dental Services under Medicaid and SCHIP.

- Provides \$50 million in financial incentives and planning grants to states in Fiscal Year 2008 and each subsequent fiscal year. To be eligible for grants, states must provide market-based payment rates for dental services under these programs at sufficient levels to enlist providers to treat enrolled children. These grants would fund administrative resources for states to develop programs, analyze data, and educate providers to improve dental care delivery in Medicaid and SCHIP.
- Allows states to use the SCHIP program to provide dental coverage for children income-eligible but not enrolled in SCHIP who have private medical insurance but lack dental insurance.

### 2) Correcting GME Payments for Dental Residency Training Programs.

- Makes an adjustment to the Medicare Graduate Medical Education payments for dental residency programs allowing faster reimbursement and thus increasing the number of residency slots available for dental residents.

### 3) Improving Delivery of Pediatric Dental Services Under Community Health Centers, Public Health Departments, and the Indian Health Service.

- Provides \$40 million in annual grants for FY2008 through FY2012 through the Health Resources and Services Administration (HRSA) to expand the availability of primary dental care services in health professional shortage areas or medically underserved areas. Licensed or certified dental health professionals who practice in Federally-designated dental health professional shortage areas or whose patient population includes at least 25 percent Medicaid, SCHIP, or uninsured individuals would also be eligible for these grants. This section also provides for multi-year retention bonuses for dental officers in the Indian Health Service to encourage more dentists to pursue careers serving Indian populations.

### 4) Improving Oral Health Promotion and Disease Prevention Programs.

- Includes a number of initiatives within the Department of Health and Human Services (HHS) to improve oral health awareness and reduce the incidence of oral health disease. Those initiatives:
  - Require the Secretary of HHS to establish an Oral Health Initiative to reduce disparities in oral health for low-income children and improve health in vulnerable populations. The Secretary is directed to encourage public-private partnerships in activities such as community water fluoridation, dental sealant programs and oral health literacy through school-based education programs.
  - Create a Chief Dental Officer for HHS programs that are critical in improving children's oral health. Establish the Chief Dental Officer for the Medicaid and SCHIP programs through the office of the Centers for Medicare

and Medicaid Services (CMS) Administrator. Establish a Chief Dental Officer for all oral health programs through the office of the HRSA Administrator. Establish a Chief Dental Officer for all oral health programs within the CDC.

- Improve reporting and surveillance of childhood dental disease by directing the CDC director to collect data through State-based oral health surveillance systems to describe the dental, craniofacial, and oral health of residents in all 50 states and certain Indian Tribes. The CDC director would submit an annual report to Congress on the above data.
- Expand existing surveillance activities to include identification of children at high risk for early childhood dental disease.
- Provide funding for a school-based dental sealant program based upon state/federal free or reduced lunch programs and federal poverty level guidelines.
- Require the CDC to award grants to States and Indian Tribes to improve the oral health of children and their families.

## Background

Experts stress that the connection between oral health and general health might be even stronger than first realized with suspected associations between certain oral diseases and systemic diseases and conditions, including diabetes, cardiovascular disease, stroke, and pre-term low birth weight babies.<sup>1</sup> Although oral diseases are nearly 100% preventable, according to the Centers for Disease Control dental caries (tooth decay) is the most common chronic disease of children age 5 to 17 years. Pain and suffering due to untreated tooth decay can lead to problems in eating, speaking, and attending to learning.<sup>2</sup> Oral health disparities and access issues are more prevalent among racial and ethnic minorities, people with disabilities, and low-income families.<sup>3</sup> Low-income children have nearly 12 times more restricted-activity days because of dental-related illness than children from higher-income families. Minority children and those with public insurance were more than twice as likely to have caries and urgent treatment needs as non-minorities or those with private insurance.<sup>4</sup>

Dental insurance is a major instrument for ensuring access to dental care services. The 2000 U.S. Surgeon General's report on oral health reported that approximately 85 million individuals in the United States had no dental insurance.<sup>5</sup> According to a report in the Journal of the American Dental Association, 77% of U.S. children have dental insurance of which 29% is public insurance. 16.3 million children lacked dental insurance. Children uninsured for dental care were less than half as likely to have received preventive dental care. The Journal report concludes that dental insurance, public or private, is associated with the receipt of preventive dental care.<sup>6</sup> In Colorado, 42 percent of adults reported not having dental insurance, and 30.5 percent of Colorado children are estimated to be without coverage.<sup>7</sup>

## Barriers to Care

### *Lack of Provider Participation in the Public Programs*

Medicaid and SCHIP reimbursement rates are too low to encourage dentist participation in these programs. Rates are often less than the cost of providing care resulting in losses to dentists when treating these patients. Dentists also complain of excessive paperwork and other billing and administrative complexities in the Medicaid program. Dentists

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<sup>1</sup> American Dental Association, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*. October 2004 <http://ada.org>.

<sup>2</sup> [http://cdc.gov/OralHealth/factsheets/dental\\_caries.htm](http://cdc.gov/OralHealth/factsheets/dental_caries.htm).

<sup>3</sup> American Dental Association, *State and Community Models for Improving Access to Dental Care for the Underserved – A White Paper*. October 2004 <http://ada.org>.

<sup>4</sup> Southward LH, Robertson A, Wells-Parker E, Eklund, NP, Silberman SL, Crall, JJ, Edelstein, BL, Baggett, DH, Parrish, DR, Hanna, H. *Oral Health Status of Mississippi Delta 3-5-year-olds in Child Care: An Exploratory Study of Dental Health Status and Risk Factors for Dental Disease and Treatment Needs*. Journal of Public Health Dent. 2006 Spring 66(2): 131-7 <http://www.ncbi.nlm.nih.gov>.

<sup>5</sup> *Oral Health Environmental Scan: Final Report* September 26, 2005 Colorado Health Institute.

<sup>6</sup> Lewis, C, Mouradian, W, Slayton, R, Williams, A. *Dental Insurance and Its Impact on Preventive Dental Care Visits for U.S. Children*. J Am Dent Assoc. 2007 Mar;138(3):369-80.

<sup>7</sup> *Impact of Oral Disease on the Health of Coloradans*, Colorado Department of Public Health and Environment Oral health Program 2005 <http://cdhpe.state.co.us>.

further complain of high rates of broken appointments in this population. The lack of providers creates significant access barriers. Medicaid reimbursement rates for dental services in Colorado have remained at the same level since FY 1999-2000. Reimbursement rates are at 68% of the American Dental Association mean (the Colorado Dental Association recommends reimbursing at 80%). Less than 12 percent of Colorado licensed dentists participate in Medicaid, with only 3 percent of Medicaid providers classified as “significant providers”.<sup>8</sup> The National Conference of State Legislatures collected information in 2000 to determine provider strength in Medicaid programs. The NCSL determined that a dentist billing for at least \$10,000 per year is considered a regular Medicaid provider. (The average amount spent on dental care for a child was \$437. This means that dentists who billed more than \$10,000 are likely to have treated more than 23 children, or about two per month.) In Colorado, fewer than 10% of dentists bill more than \$10,000.<sup>9</sup>

#### *Lack of Providers in Rural and Underserved Areas*

According to a CDC Survey of State Dental Public Health Programs in 2005, there are 11 counties in Colorado without any dentists at all. Across the county and in Colorado, lack of providers in rural and underserved areas presents a significant barrier to accessing care. Although related to the problem of provider participation in the public insurance programs it’s a problem that presents challenges of its own in terms of encouraging dentists to practice in rural areas.

#### *CHP+ and Medicaid in Colorado*

The addition of a dental benefit to CHP+ in Fiscal Year 2000-2001 has allowed more children in the state to receive dental care. An analysis by the University of Colorado School of Dentistry showed that 34 percent of enrolled CHP+ children received a dental care service in the initial year of the CHP+ dental benefit. Similarly, in FY 2000-01 only 24% of Medicaid children in Colorado received any dental services.<sup>10</sup> The disparity is likely the result of the fact that reimbursement rates for CHP+ dental services are slightly higher than for Medicaid services. However, there is a cap for CHP+ dental services. The \$500 annual CHP+ dental services cap has resulted in some children not being able to complete needed dental treatment during a calendar year. The CHP+ cap has been fixed since the inception of the program and is not indexed to inflation. Safety net dental services such as Delta Dental’s Smile-a-bration attempt to fund dental needs above the \$500 threshold but this is not always possible resulting in incomplete dental treatment. The Children’s Dental Health Project, a national child dental health advocacy organization, notes, “Experience in multiple states substantiates that failure to index dental fees and the annual cap to inflation results in rapid erosion of provider participation as the value of these dollar amounts diminishes over time.”<sup>11</sup>

#### *Racial Disparities in Access to Care*

A report by the Colorado Department of Public Health and Environment entitled the *Impact of Oral Disease on the Health of Coloradans 2004* examined the state of oral health in Colorado. According to this report Colorado is ranked sixth highest in dentists per capita in the nation, with a dentist-to-population ratio of 56.5 per 100,000 in 1998. However, this represents a 15 percent decrease since 1991, which may indicate a future shortage trend. A diverse dental workforce and one able to service low-income populations is key to addressing the unmet needs of minority patients in Colorado. Only 11 percent of the dental workforce is non-white compared to 25 percent of the state population resulting in another barrier to health care for minority populations. A report by the Colorado Department of Public Health and Environment concludes that race-associated differences in health outcomes are in fact due to the effects of racism, discrimination, and systemic biases that have resulted in multiple barriers to optimal health for communities of color.<sup>12</sup>

#### **Why is this issue important?**

Because childhood is the developmental stage during which both primary and permanent teeth are formed, childhood oral health has both immediate and long-term consequences. The importance of focusing on childhood dental disease is twofold: It involves a critical period during which preventive dental care reaps the greatest effect before dental disease affects primary and permanent teeth, and it increases the probability of improving overall health and well-being of adults over their lifespan.<sup>13</sup>

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<sup>8</sup> *Impact of Oral Disease on the Health of Coloradans*, Colorado Department of Public Health and Environment Oral health Program 2005 <http://cdhpe.state.co.us>.

<sup>9</sup> Gehshan, S., et al. 2001 “Increasing Dentists’ Participation in Medicaid and SCHIP.” National Conference of State Legislatures Promising Practices Issue Brief: Forum for State Health Policy Leadership.

<sup>10</sup> *Oral Health Snapshot* <http://cdphe.state.co.us/pp/oralhealth/snapshot.html>.

<sup>11</sup> *Oral Health Environmental Scan Final Report* September 26, 2005 Colorado Health Institute.

<sup>12</sup> Hunsaker, Jill A., MPH, *Profile of Health Disparities among Communities of Color, Colorado 2001* Colorado Turning Point Initiative CDPHE.

<sup>13</sup> *Oral Health Environmental Scan Final Report* September 26, 2005 Colorado Health Institute.

There is significant unmet need for dental services in Larimer County. The Health District provided care to 3,200 individuals in nearly 9,000 visits in 2006. Yet estimates indicate that there are at least 7,100 Health District children and adults (and possibly as many as 18,600) who are eligible for sliding fee scale services at the Health District because they have an income at or below %185 of federal poverty level and are without dental coverage (with the exception of Medicaid or CHP+ for children). Currently the Health District has a list of about 350 adults who are waiting to be admitted into the practice as regular patients receiving ongoing routine care, which can take up to seven months. The Health District Community Health Survey (CHS) performed in 2004 showed that 31% of residents with low incomes reported currently having a toothache and/or gum problems. In 2004, 52% of residents with low incomes had not had a dental exam and/or teeth cleaning within the recommended guidelines, and 61% had put off a dental visit because of cost (compared to 35% who had put off a visit due to cost among those who had higher incomes). Locally, for every adult without medical insurance, four are without dental coverage.

**Reasons to support bill:**

- If appropriately funded, the bill has the potential to increase the number of providers practicing in rural and medically underserved areas.
- Wraparound dental coverage for kids who are income eligible for the SCHIP program but not enrolled because their parents have access to private insurance would achieve a higher rate of insurance coverage around a child population that is underinsured in terms of dental. Boosting insurance coverage would likely achieve greater accessing of dental care by those kids.
- The bill aims to significantly raise the profile of the issue of oral health. The creation of an Oral Health Initiative and the institution of Chief Dental Officers in a number of federal agencies could go a long way toward focusing long needed attention on the problem of inadequate dental care especially among low-income children and racial and ethnic minorities.
- The bill addresses some of the best practices identified by the Colorado Health Institute in its report on oral health. For example, best practices include public water system fluoridation and school-based interventions including fluoride rinses and dental sealant programs both of which are encouraged and promoted in the bill. According to a CDC Survey of State Dental Public Health Programs in 2005, there are 5 school-based dental clinics providing preventive dental services and about 75% of the people in Colorado are on public water systems that provide fluoridated water.

**Reasons to oppose bill:**

- Although not a reason to oppose the bill, some of the grants are only available to states that raise Medicaid reimbursement rates for dentists. The bill does not provide any federal funding to help increase rates and Colorado would have to show a significant dedication to enhancing access to oral healthcare through its public insurance programs by increasing reimbursement rates.
- Conservatives might oppose the bill because it is an expansion of public insurance programs rather than supporting the private insurance market.

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**About this Analysis**

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. Analyses are based on bills or issues at the time of their consideration by the Board and are accurate to the best of staff knowledge. It is suggested that people check to see that a bill has not changed during the course of a legislative session by visiting the Colorado General Assembly web page at [www.state.co.us/gov\\_dir/stateleg.html](http://www.state.co.us/gov_dir/stateleg.html). To see whether the Health District Board of Directors took a position on this or other policy issues, please visit [www.healthdistrict.org/policy](http://www.healthdistrict.org/policy).

**About the Health District**

The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves.

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