Medicaid and Dental Care for Children

Elicia J. Herz
Specialist in Health Care Financing

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Summary

According to guidelines published by the American Academy of Pediatric Dentistry, all youth should see a dentist for routine dental screening and preventive care twice a year. Dental care is a mandatory benefit for most Medicaid eligibles under the age of 21, however, nationwide, the majority of low-income children enrolled in Medicaid do not receive any dental services in a given year. There are many beneficiary and provider-related issues that contribute to inadequate access to and delivery of dental care. To address this problem, some states have undertaken new Medicaid initiatives to attract and retain dental providers that may serve as models for other state Medicaid programs.

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Lack of regular dental care can result in pain, infection, and delayed diagnosis of oral diseases. During the 2001-2004 period, one-fourth to one-third of children ages 2 to 19 in families with income below 200% of the federal poverty level (FPL)[1] experienced untreated dental caries (decay), a sign that needed dental care was not received. In 2005, about one-third of all children living below 200% FPL did not have a recent dental visit.[2] In a related study, GAO found that during the 1999-2004 period, roughly one in three Medicaid children ages 2 through 18 had untreated tooth decay, and data from 2004 through 2005 indicated that only 37% received any dental care over a one-year period.[3]

With respect to receipt of dental services, insurance matters. In 2006, 50.9% of individuals under the age of 21 in the United States had private dental coverage, another 30.4% had public dental coverage (primarily Medicaid and SCHIP), and 18.7% had no dental coverage. The percentage of individuals under age 21 that had a dental visit in 2006 varied by type of coverage—58.0% with private dental coverage had a dental visit that year, compared with 35.1% of those with public dental coverage and 26.3% of the subgroup with no dental coverage.[4]

The American Academy of Pediatric Dentistry (AAPD) recommends that every child be seen by a dentist following the eruption of the first tooth, but not later than 12 months of age. All other children should have additional periodic dental exams every six months (i.e., twice a year). Under Medicaid, states must adopt a dental periodicity schedule, which can be state-specific based on consultation with dental groups, or may be based on nationally recognized dental periodicity schedules, such as the AAPD's guidelines.[5]

One goal of the *Healthy People 2010* initiative, a federal effort to increase quality and years of healthy life and eliminate health disparities, is that at least 66% of low-income children receive a preventive dental visit each year.[6] Most Medicaid children under age 21 are entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.[7] The Medicaid statute (Section

[1] In 2004, for example, the federal poverty level for a family of four was equal to $18,850 (see 69 *Federal Register* 7336, February 13, 2004).

[2] National Center for Health Statistics, *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*, Hyattsville, MD: 2007. Hereafter referenced as *Health, United States, 2007*.

[3] Testimony by Alicia Puente Cackly, Acting Director, Health Care, Government Accountability Office, *Medicaid: Extent of Dental Disease in Children Has Not Decreased*, before the Subcommittee on Domestic Policy, House Committee on Oversight and Government Reform, September 23, 2008.

[4] See Manski, R.J. and Brown, E. *Dental Coverage of Children and Young Adults Under Age 21, United States, 1996 and 2006.* Statistical Brief 221. September 2008. Agency for Healthcare Research and Quality, Rockville, MD, at http://www.meps.ahrq.gov/mepsweb/data_files/publications/st221/stat221.pdf

[5] As per 42 CFR 441.58; also see Centers for Medicare and Medicaid Services (CMS), *Guide to Children's Dental Care in Medicaid*, October 2004, and the American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment of Children*, 2003.

[6] Originally, a goal of 57% was set for this participation rate (see U.S. Department of Health and Human Services. *Healthy People 2010.* Second Edition. Washington, DC: U.S. Government Printing Office, November 2000). A subsequent review increased that goal to 66% (see U.S. Department of Health and Human Services, *Progress Report: Oral Health*, February 7, 2008).

[7] While EPSDT is a mandatory benefit for the majority of Medicaid beneficiaries under 21, a small subset classified as "medically needy" may receive EPSDT at state option. Although an official count is not available, it is likely that all states currently provide EPSDT to this group. In addition, as an alternative to traditional Medicaid benefits, the Deficit Reduction Act (DRA) of 2005 allows states to offer benchmark benefit packages similar to coverage in the employer-based insurance market to many groups of Medicaid beneficiaries. This DRA option provides access to EPSDT as a "wrap-around" to these benchmark plans for Medicaid beneficiaries under age 19; in other words, states that use the DRA benchmark plan option must still provide EPSDT services to this sub-population when the benchmark plans do (continued...)

1905(r)) defines required EPSDT screening services to include dental services that, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. In addition, care that is necessary to correct or ameliorate identified problems must also be provided, including services that states do not otherwise cover in their Medicaid programs. Beneficiary cost-sharing for services such as dental care is prohibited for children under age 18, and is optional for those ages 18-20.[8] Federal law is intended to eliminate or significantly reduce major barriers to dental services for Medicaid children.

Nonetheless, the research literature has identified several factors that affect the use of dental services among children. From a beneficiary perspective, barriers include, for example, ability to pay for care, navigating government assistance programs, finding a dentist who will accept Medicaid, locating a dentist close to home (especially in inner-city and rural areas), getting to a dentist office, cultural or language barriers, and lack of knowledge about the need for periodic oral health care.[9]

Most of the dental care provided in the United States is delivered by private dentists. In contrast to physician services, about half of all payments for dental services are made out-of-pocket, rather than through insurance. In addition, overhead in dental practices is high, averaging about 60 cents for every dollar earned, due in part to the need for expensive equipment. New dentists also face substantial debt because of the high cost of dental education.[10]

While there are questions about whether there is an overall shortage of dentists in the United States, there is general agreement that too few provide services to those who are publicly funded and those with special needs. Federal Medicaid law and regulations require that payment rates be sufficient to enlist enough providers so that services are available at least to the same extent that such services are available to the general population in the geographic area.[11] Nonetheless, reimbursement rates are an obstacle to such participation.

In addition to reimbursement rates, dentists typically cite two other reasons for their low participation rates in Medicaid: burdensome administrative requirements and patient behavior (e.g., infrequent care-seeking behavior and high no-show rates for dental appointments).[12] A

(...continued)

not cover this benefit.

[8] Under the DRA, cost-sharing is prohibited only for children in mandatory eligibility categories (e.g., those under age 18 who are covered through mandatory cash assistance-related eligibility groups) and certain foster care/adoption assistance children. Such children may nonetheless be subject to nominal cost-sharing for non-emergency use of an emergency room and prescribed drugs at state option.

[9] *Health, United States, 2007*.

[10] For more information on Medicaid payment rates, characteristics of dental practices, and factors that influence Medicaid participation among dentists, see, for example, S. Gehshan and M. Wyatt, *Improving Oral Health Care for Young Children*, National Academy for State Health Policy, April 2007; L.J. Brown, *Adequacy of Current and Future Dental Workforce: Theory and Analysis.* Chicago, IL: American Dental Association, Health Policy Resources Center, 2005,and Jane S. Grover, American Dental Association, testimony before the Domestic Policy Subcommittee, House Oversight and Government Reform Committee at the hearing *Necessary Reforms to Pediatric Dental Care Under Medicaid*, September 23, 2008.

[11] As per Section 1902(a)(30)(A) of the Social Security Act and 42 CFR 447.204.

[12] See, for example, S. Gehshan and M. Wyatt, *Improving Oral Health Care for Young Children*, National Academy for State Health Policy, April 2007, and A. Borchgrevink, A. Snyder, and S. Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, National Academy for State Health Policy, March, 2008.

recent study of physicians also shows a negative relationship between administrative issues (delays in receiving payments) and participation in Medicaid.[13]

Receipt of Dental Services Among EPSDT Participants

The Medicaid statute (Section 1902(a)(43)) requires states to inform and arrange for the delivery of EPSDT services to eligible children, and also includes annual reporting requirements for states. The tool used to capture these required EPSDT data is called the CMS-416 form. The current CMS-416 form (effective as of FY1999) includes the unduplicated count of EPSDT eligibles by age and basis of eligibility who receive (1) any dental services, (2) preventive dental services, and (3) dental treatment services. Classification into one of these measures is based on specific dental procedure codes recorded on provider claims.

Across states in FY2006, use of dental services among Medicaid children was generally low, as shown in **Table 1**. Receipt of *any* dental services among Medicaid children eligible for EPSDT ranged from 18.9% (in North Dakota) to 55.7% (in West Virginia). Receipt of *preventive* dental services ranged from 6.7% (in Utah) to 51.0% (in Vermont). Finally, receipt of dental *treatment* services ranged from 6.4% (in Nevada) to 40.8% (in West Virginia).

Table 1. Percentage of EPSDT Eligibles Receiving Dental Services, by Type and State, FY2006

States	Any Dental Services	Preventive Dental Services	Dental Treatment Services
Alabama	37.0	33.1	19.9
Alaska	39.3	31.6	21.8
Arizona	33.6	28.0	18.2
Arkansas	26.8	23.8	24.1
California	28.2	23.0	15.5
Colorado	34.5	28.6	17.6
Connecticut	33.2	27.6	14.1
Delaware	29.2	25.7	14.7
District of Columbia	26.2	22.1	15.3
Florida	20.9	13.3	7.8
Georgia	35.0	32.4	17.1
Hawaii	40.8	33.3	21.4
Idaho	40.4	34.1	25.2
Illinois	35.6	32.2	28.1

[13] Peter J. Cunningham and Ann S. O'Malley, Do Reimbursement Delays Discourage Medicaid Participation by Physicians? *Health Affairs—Web Exclusive*, November 18, 2008, w17-w28.

States	Any Dental Services	Preventive Dental Services	Dental Treatment Services
Indiana	41.4	37.0	22.1
Iowa	42.5	36.8	18.6
Kansas	36.1	32.8	18.2
Kentucky	32.9	24.9	19.7
Louisiana	27.6	23.1	15.0
Maine	NA	NA	NA
Maryland	30.7	25.4	13.0
Massachusetts	37.7	33.6	22.6
Michigan	30.0	29.0	12.6
Minnesota	33.7	29.6	16.7
Mississippi	35.2	27.3	19.3
Missouri	23.8	20.7	14.2
Montana	24.5	20.6	13.5
Nebraska	44.2	39.5	22.0
Nevada	19.7	15.7	6.4
New Hampshire	41.8	37.5	19.7
New Jersey	25.9	21.2	15.3
New Mexico	41.3	37.3	40.5
New York	27.4	19.7	14.3
North Carolina	39.3	35.0	18.5
North Dakota	18.9	15.6	9.0
Ohio	35.6	30.7	16.0
Oklahoma	36.7	33.9	17.6
Oregon	31.0	25.3	16.0
Pennsylvania	27.2	22.6	13.1
Rhode Island	37.7	31.2	18.3
South Carolina	—	—	—
South Dakota	34.2	29.9	12.5
Tennessee	36.3	31.7	18.8
Texas	42.5	36.4	21.8
Utah	31.8	6.7	14.3
Vermont	52.3	51.0	22.6
Virginia	31.8	28.5	16.3
Washington	42.2	38.9	21.0
West Virginia	55.7	35.2	40.8
Wisconsin	21.2	17.8	9.8

States	Any Dental Services	Preventive Dental Services	Dental Treatment Services
Wyoming	33.0	28.0	17.9
All Reporting States	32.8	27.7	17.5

Source: FY2006 Form 416 data from CMS as of December 23, 2008. Data for Maine are missing. Data for South Carolina are omitted due to reporting problems.

Note: NA = not available. "Any dental services" includes all such care. "Preventive dental services" and "dental treatment services" are mutually exclusive.

During routine immunization and well-child visits, there are a number of opportunities for physicians to inform parents about the need for dental services for their children. Guidance from the American Academy of Pediatrics for well-child visits during 2006 (in effect since 2000) called for initial dental referrals at age three years, or as early as one year of age when indicated.[14]

Table 2 provides a more detailed analysis of the receipt of preventive dental services by age in FY2006. Across age groups within each state and for all reporting states as a whole, utilization patterns resembled a bell-shaped curve (see **Figure 1**). That is, children at the age extremes tended to receive fewer preventive dental services than children in the middle of the age range. Among nearly all states, the highest rates of preventive dental care were observed for the six- to nine-year-old age group. For this age group, 10 states[15] had preventive dental rates over 50%, and one state (Vermont) met the Healthy People 2010 goal that at least 66% of such children receive a preventive dental visit.

The higher rates of preventive dental care among children aged six to nine may be related in part to school entry requirements for childhood immunizations. In order to attend kindergarten at ages five and six, for example, all states require that children have received common childhood immunizations (e.g., vaccinations for diphtheria, tetanus, and acellular pertussis, or DTaP; measles, mumps, and rubella, or MMR; and polio).[16] When children receive those immunizations, health care providers may make referrals for other health services, including dental care.

Table 2. Percentage of EPSDT Eligibles Receiving Preventive Dental Services, by Age Group and State, FY2006

		Age Groups						
States	Total	< 1	1-2	3-5	6-9	10-14	15-18	19-20
Alabama	33.1	0.2	11.7	46.5	48.9	43.5	31.6	4.3
Alaska	31.6	0.0	6.5	33.8	45.3	43.6	34.9	16.5
Arizona	28.0	0.0	3.3	33.4	48.5	41.9	25.1	10.4

[14] More recent 2008 guidance includes more frequent referrals to a dental home, if available, or if not, oral health assessments by physicians beginning at six months of age through age six years. For more information, see http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf.

[15] These states were Georgia, Idaho, Illinois, Indiana, Nebraska, New Hampshire, New Mexico, Texas, Vermont, and Washington.

[16] For detailed information on immunization requirements by type and state as of August 2006, see http://www.cdc.gov/vaccines/vac-gen/laws/downloads/izlaws05-06.pdf.

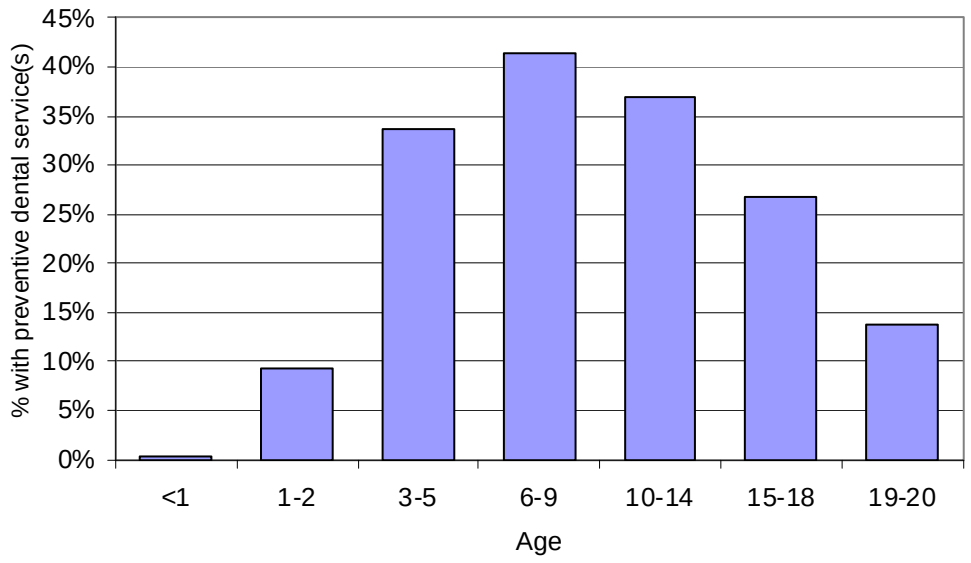
States	Total	Age Groups						
		< 1	1-2	3-5	6-9	10-14	15-18	19-20
Arkansas	23.8	0.2	10.3	33.0	38.3	32.7	23.5	2.1
California	23.0	0.0	5.3	26.8	34.9	32.0	23.1	13.0
Colorado	28.6	0.2	11.5	34.8	43.1	38.8	29.7	13.6
Connecticut	27.6	0.1	5.9	31.2	42.7	37.4	24.6	9.7
Delaware	25.7	0.0	2.6	32.0	41.6	36.4	23.6	10.7
District of Columbia	22.1	0.0	4.5	30.8	31.5	28.2	20.5	9.8
Florida	13.3	0.0	2.3	16.1	20.8	18.7	13.1	6.0
Georgia	32.4	0.0	6.4	42.5	51.5	45.4	32.2	15.4
Hawaii	33.3	0.5	22.3	46.1	46.0	39.3	27.4	11.2
Idaho	34.1	0.2	7.8	35.6	50.3	46.6	37.1	19.1
Illinois	32.2	0.4	9.9	45.7	50.3	39.4	21.6	6.4
Indiana	37.0	0.0	9.0	42.0	55.3	49.6	37.5	19.0
Iowa	36.8	5.6	17.9	44.2	47.8	45.4	38.7	31.1
Kansas	32.8	0.2	7.9	39.8	49.8	46.0	37.3	16.2
Kentucky	24.9	0.1	4.2	28.0	36.6	34.5	28.3	16.8
Louisiana	23.1	0.0	5.3	29.7	32.7	28.7	22.6	9.5
Maine	NA	NA	NA	NA	NA	NA	NA	NA
Maryland	25.4	0.5	3.9	28.2	37.0	33.9	26.1	22.7
Massachusetts	33.6	0.1	5.9	39.3	48.5	45.8	35.4	17.8
Michigan	29.0	0.1	3.6	34.1	44.6	37.3	28.4	16.8
Minnesota	29.6	0.2	3.4	34.0	44.1	42.2	33.6	20.4
Mississippi	27.3	0.9	7.0	40.1	36.5	33.5	29.7	32.2
Missouri	20.7	0.0	1.9	22.5	31.9	29.0	21.1	8.2
Montana	20.6	0.2	4.7	23.6	30.0	26.9	20.2	8.6
Nebraska	39.5	4.8	7.7	44.7	57.9	55.2	42.3	24.8
Nevada	15.7	0.6	5.4	18.9	25.3	22.8	16.0	5.4
New Hampshire	37.5	0.1	6.3	38.7	52.9	49.8	41.7	19.9
New Jersey	21.2	0.1	4.2	24.4	31.6	28.7	21.5	12.4
New Mexico	37.3	0.2	12.7	43.4	55.5	48.5	32.9	15.7
New York	19.7	0.1	3.3	22.6	30.7	27.7	19.5	14.0
North Carolina	35.0	5.8	37.8	38.2	45.4	41.5	30.0	14.4
North Dakota	15.6	0.0	1.1	19.0	24.7	23.0	16.0	7.8
Ohio	30.7	0.1	5.6	37.4	44.9	39.7	29.9	17.5
Oklahoma	33.9	0.2	9.4	37.6	48.3	46.1	36.1	18.1
Oregon	25.3	0.2	8.5	30.0	38.4	34.0	26.9	15.4
Pennsylvania	22.6	0.0	2.6	25.0	34.3	30.8	23.8	13.1

States	Total	Age Groups						
		< 1	1-2	3-5	6-9	10-14	15-18	19-20
Rhode Island	31.2	0.0	1.5	27.4	48.3	44.0	32.2	16.2
South Carolina	—	—	—	—	—	—	—	—
South Dakota	29.9	0.2	7.4	35.8	44.0	39.8	29.5	16.8
Tennessee	31.7	0.0	5.5	34.2	47.9	45.8	34.8	17.4
Texas	36.4	0.0	25.3	46.3	50.8	46.5	31.9	14.8
Utah	6.7	0.1	2.6	7.8	13.5	12.1	6.6	1.7
Vermont	51.0	0.3	13.6	53.7	67.1	63.9	55.4	35.2
Virginia	28.5	0.1	5.5	33.1	42.6	39.9	30.5	12.0
Washington	38.9	1.3	22.7	47.9	53.5	46.5	34.4	13.2
West Virginia	35.2	0.2	9.1	44.9	48.5	46.6	36.1	8.5
Wisconsin	17.8	0.3	5.0	22.6	28.8	25.1	15.5	4.6
Wyoming	28.0	0.2	4.0	30.4	43.8	40.5	32.3	14.4
All Reporting States	27.7	0.4	9.2	33.7	41.4	37.0	26.8	13.7

Source: FY2006 Form 416 data from CMS as of December 23, 2008. Data for Maine are missing. Data for South Carolina are omitted due to reporting problems.

Note: NA = not available.

Figure 1. Percentage of EPSDT Eligibles Receiving Preventive Dental Services, by Age Group for All Reporting States Combined, FY2006



Source: Data taken from **Table 2**, above.

Emerging Models for Dental Care for Medicaid Children

Many states recognize that dental care is underutilized across most Medicaid sub-populations. In a September 2008 hearing[17] before the Domestic Policy Subcommittee of the House Committee on Oversight and Government Reform, state officials and other representatives from Maryland, Virginia, North Carolina, and Georgia, and from the dental profession, described recent state actions to improve dental care for Medicaid children. Their recommendations included the following:

- increase dental reimbursement rates to make them more in line with private market-based rates;
- remove administrative barriers (e.g., prior authorization for certain procedures, simplified claims, and use of electronic billing);
- carve out dental benefits from managed care contracts and use a single dental vendor to establish a more stream-lined approach to processing claims and paying providers;
- when designing new dental program features, involve dentists and professional dental organizations;
- establish dedicated dental units in state governments to help guide policy decisions; and
- establish "dental extenders" to increase service capacity, including for example, (1) primary care medical professionals to provide oral evaluation and risk assessment, counseling for parents about oral hygiene, and application of fluorides,[18] and (2) other allied dental providers that can do community outreach and education, and perform preventive services such as fluoride and sealant application, potentially expanding to additional dental treatment services.[19]

Other states may draw lessons from these experiences and recommendations. With respect to the final point above, provider groups hold varying opinions about the extent to which non-dentists can and should provide certain dental services. States may need to address such issues if they wish to expand access to dental care under Medicaid for children and other sub-groups.

[17] See testimony at http://domesticpolicy.oversight.house.gov/story.asp?ID=2192.

[18] Also see, for example, American Academy of Pediatrics, *Preventive Oral Health Intervention for Pediatricians*, Pediatrics, vol. 122, no. 6, pp. 1387-1394, December 2008.

[19] Also see, for example, Snyder, A., and Gehshan, S. *State Health Reform: How Do Dental Benefits Fit In? Options for Policy Makers.* National Academy for State Health Policy, April 2008.

Author Contact Information

(name redacted)
Specialist in Health Care Financing
/redacted/@crs.loc.gov, 7-....

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