

# Child Policy Brief



## Dental Care

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Inadequate access to dental care is a major problem for Georgia's low-income children. Dental caries (tooth decay) is the single most common chronic childhood disease — 5 times more common than asthma. Pain and suffering due to untreated diseases lead to problems in eating, speaking, and paying attention in school. According to Georgia's teachers, dental problems are one of the two most frequently cited reasons that children miss school (along with vision problems.)

Low-income families seeking dental care in Georgia are very frustrated. Insurance, either Medicaid or PeachCare for Kids, is not a guarantee of access to care. Only about one quarter of Medicaid and PeachCare children (200,000 out of 800,000 children) were able to see a dentist in FY2000, though more than twice that number sought care. Low-income families without insurance are even less likely to get dental care, according to national studies. In Georgia, the uninsured (about 300,000 children) only have access through the Oral Health Program of the Department of Public Health. In FY2000, it provided screening and referral services to 81,000 children, but it can not treat many of the children who have dental diseases.

Georgia has begun addressing the dental crisis by raising dentists' Medicaid and PeachCare rates. Rate hikes in July 1998 and July 2000 have made public payments competitive with private payments, addressing the number one reason dentists give for not seeing more public patients. In this paper, we examine the likely impact of recent changes and propose actions that are needed to gain access for every child.

### Likely Impact Of Recent Changes

The 1998 rate change was small and had little effect, and it is too soon to measure the impact of the rate increase from July 2000. However, based on four other states that have made similar payment changes, we expect to see four things happen sequentially in Georgia. At first, these changes could raise concerns, because spending will increase before access increases.

1. The same volume of services will cost more, as price per procedure has increased.
2. The volume of procedures for children already accessing care will increase as their needs are more comprehensively and appropriately met.
3. The number of children obtaining care will increase as participating dentists increase their volume of Medicaid and PeachCare patients.
4. The volume of dentists who participate in Medicaid and PeachCare will increase as the dental community becomes more involved, particularly through peer communication that "the program works".

Other steps taken by the Division of Medical Assistance (DMA) will help speed Georgia along this path. In July 2000, DMA simplified administrative procedures for dentists and began working with the Georgia Dental Association to publicize the changes to dentists and recruit more dentists to participate. While these changes can be expected to increase access significantly, we estimate a third or more of Medicaid and PeachCare children will still not have access to dental care because of capacity ("supply side") limitations relative to need and demand for care.

### What Else Can Georgia Do?

A recent survey of other states showed significant legislative activity to address dental access problems across the country. Some of the ideas suggest improvements Georgia could try

- After low reimbursement, dentists report "broken appointments" as the top problem in providing effective care to low- and moderate-income families. Alabama began a program to address this issue in October, 2000. They use caseworkers paid with Medicaid and/or Title V funding (Maternal and Child Block Grant) to assist families who have missed an appointment. Dentists can refer a family to the caseworkers who will then reschedule the appointment and help families keep it. It is too soon to know if the program is working, but it is popular among dentists.

- Provide scholarships to dental school or loan repayment programs for dentists to work in underserved areas if they see Medicaid and PeachCare kids (Maine and Maryland).
- Locate satellite clinics of dental schools in underserved areas and have dental faculty and students staff them (New York and Connecticut).
- Enhance provider relations by strengthening provider service and outreach, and instituting programs that complement dentists' needs. The state could create a purchasing cooperative only available to participating dentists or offer free continuing education to Medicaid dentists on topics highly relevant to the Medicaid population, such as cultural competence, children with special needs, treating patients with language barriers, etc.

Other experiments are underway to tap into existing capacity. Vermont's oral health program is partnering with underused private offices to let public practice dentists deliver services there at off times. Though critics have opposed large public dental systems because it is hard to recruit dentists and the duplicate infrastructure is inefficient, there are situations, as in Vermont, where they may work.

Finally, a frequently mentioned idea is to use independent dental hygienists to substitute for dentists. However, hygienists

are trained to provide only preventive care, and would not be able to treat cavities or gum disease, which are the biggest needs in Georgia.

A Georgia summit on improving oral health access for children is being planned by the Division of Public Health for Spring 2001. A Georgia Oral Health Initiative Advisory Partnership is being formed including key executive and legislative branch officials, provider associations, and the Medical College of Georgia, School of Dentistry. The goal of the summit is to discuss collaborative approaches that can increase access to dental care.

### Conclusion

Georgia's dental system, both private and public, does not have sufficient capacity to assure dental access to all low-income children. If the state is going to succeed in helping all children be ready for and productive in school, dental access is an essential problem to address. There is a need for leadership and coordination between the two primary programs providing dental services for low-income children, as well as ongoing monitoring and evaluation to examine the impact of recent and future changes. Piloting new activities in different parts of the state may make it easier to determine the most successful approaches.

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### Georgia's Dental Capacity

Georgia has 3,900 private practice dentists. 18 counties and parts of 10 others are designated by the Federal government as Dental Health Professional Shortage Areas.

The Georgia Oral Health Prevention Program, run by the Department of Public Health, funds school-based dental prevention services in the areas of the state with the most low-income children. Other dental public health resources include 43 public health department dental clinics, serving 64 counties, and six community health centers with dental facilities. Fulton County funds mobile dental vans to serve hard to reach populations.

Dental shortages for low-income families tend to be most acute when the economy is strong, as higher income people choose to buy dental care. When the economy slows down, low-income families find it easier to get appointments, unless public programs make cutbacks in provider payments.

### State Expenditures for Children's Dental Services

	Medicaid and PeachCare		Division of Public Health	
	\$ million	Children	\$ million	Children*
FY98	27.5	200,397	1.4	129,175
FY99	35.9	195,117	1.4	60,974
FY00	38.4	204,047	1.4	81,676
FY01 (bud.)	59.9	Unavailable	2.4	Unavailable

\*Combined state and local oral health initiatives.