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ORAL HEALTH BENEFITS IN MEDICAID

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The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity and the engagement of patients, families, and communities.

In the Medicaid program, oral health benefits are required for Medicaid patients under the age of 21 through the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) have access to oral care. However, it has been found that utilization of oral care services is inconsistent across states.[1,2,3,4,5] While all low-income children have access to oral care, access to oral health care for adults widely varies as states have the authority to decide whether they will offer a basic emergency dental benefit or a more robust scope of services.

Pediatric Oral Health Care in Medicaid and CHIP

Under the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, oral health services must be:

> ***"provided at intervals that meet reasonable standard of dental practice, as determined by the state after consultation with recognized dental organizations involved in child health, and at such other intervals, as indicated by medical necessity, to determine the existence of a suspected illness or condition."[6]***

The requirements outlined in the EPSDT benefit afford states wide latitude in determining required oral health services, resulting in wide variation in the scope of benefits provided to children. However, at a minimum, states must offer relief of pain and infections, restoration of teeth, and maintenance of oral health.

Additionally, the source of coverage for the pediatric population, whether it is Medicaid expansion or separate Children's Health Insurance program (CHIP), introduces variability in coverage of services. In states where children are covered through Medicaid expansion, coverage for oral health services is provided under the EPSDT benefit. However, in states where children are covered by a separate CHIP program, the state is only required to provide oral health services "necessary to prevent disease and promote oral health, restore oral structure to health and function, and treat emergency conditions."[7] In the separate CHIP program, the state may choose from one of two options when structuring oral health benefits: 1) a package of oral health benefits meeting EPSDT requirements; or, 2) a benchmark dental benefit package.

The benchmark dental benefit package may take three forms:

1. The most popular federal employee dental plan for dependents;
2. The most popular plan selected for dependents under the state's employee dental plans; or,
3. Dental coverage by the most popular commercial insurer in the state.

In recent years, the concept of the pediatric dental home has become increasingly popular, especially for Medicaid-eligible children. The American Academy of Pediatric Dentists (AAPD) defines dental homes as an "ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way."[8] The AAPD recommends that pediatricians refer their patients for oral health exams by one year of age to establish the child's dental home.[8] Some states, like Iowa and Texas, have created dental home models for their Medicaid-eligible children to encourage primary prevention, education, and care coordination.

Disparities in Pediatric Oral Health Care

The variation in the scope and breadth of oral health benefits across the states is a concern for policymakers focused on maximizing access to oral health benefits, especially for children living below 200 percent of the federal poverty level (FPL) and African American and Hispanic children who are more likely to be affected by poor oral health.[3] Furthermore, while children have access to oral health services, research shows that these benefits are widely underutilized.

- According to data collected by the Centers for Medicare and Medicaid Services (CMS) for the EPSDT benefit, on average, 46 percent of Medicaid-eligible children received preventive oral health services and 24.5 percent received oral health treatment in 2013. [5]
    - Notably, the median rate of preventive oral health services increased by three percentage points from 2011. However, oral health treatment declined by one percentage point from 2011.[5]

- Additional data collected by the Office of Inspector General (OIG) found that more than a quarter of Medicaid-eligible children did not receive any oral health services over a two-year period.[9*]
    - The OIG found that in four states (California, Indiana, Louisiana, and Maryland), 28 percent of children who were continuously enrolled did not receive any oral health services over a two-year period.[9]
    - An additional 14 percent of children had only one visit to the dentist during the two-year period.[9]
    - Children younger than three years old were the least likely to receive oral health services when compared to children in the other age groups.[9]

* Note: While the OIG report cited provides data points on a number of aspects concerning the access and utilization of pediatric oral health benefits, there are a few limitations that must be noted. The data used to inform the report is based on 2012 data and does not account for the sweeping changes that have occurred across the states as a result of the Affordable Care Act. Additionally, the report conflates requirements for pediatric periodicity schedules, referring to the AAPD periodicity schedule while the EPSDT benefit relies on the Bright Future/American Academy of Pediatric's periodicity schedule.

- Notably, 41 percent of children under three did not receive oral health care over a two-year period, compared to 21 percent of children six to nine years of age.[9]
- Children in rural areas were slightly less likely than children in urban areas to receive oral health services.[9]
- Fifty percent received some—but not all—of the required oral health services over a two-year period.[9]

- Recent analysis by the American Dental Association (ADA) found that oral health care utilization among Medicaid-eligible children reached 41 percent in 2010.[2]
    - The ADA found that all states except Florida, Ohio, and Wisconsin experienced an increase in oral health utilization between 2000 and 2010.[2] Five states experienced above-average increases in oral health utilization (controlling for initial utilization levels), including Idaho, Maryland, Oklahoma, Texas, and Vermont.[2] The increase in utilization might be attributed to the transition of Medicaid coverage from fee-for-service (FFS) to managed care organizations (MCOs). However, disparities remain constant.[2]

CMS reported common challenges in addressing disparities in the utilization of oral health services among the pediatric population, including:[5]

- Insufficient enrollment of oral health providers in a state's Medicaid program;
- Lack of available oral health providers within neighborhoods;
- Lack of transportation to oral health providers;
- Language barriers; and,
- Lack of awareness of oral health benefits.

Adult Oral Health Benefits

Since federal law does not require state Medicaid programs to provide oral health benefits to the adult population, access to oral health care is considered an optional benefit. As a result, the amount, duration, and scope of oral health benefits for adult Medicaid patients is widely variable across states (Figure 1). Recently, the Medicaid and CHIP Payment and Access Commission (MACPAC) focused their attention on adult oral health benefits, publishing a detailed report in June 2015 that found:[1]

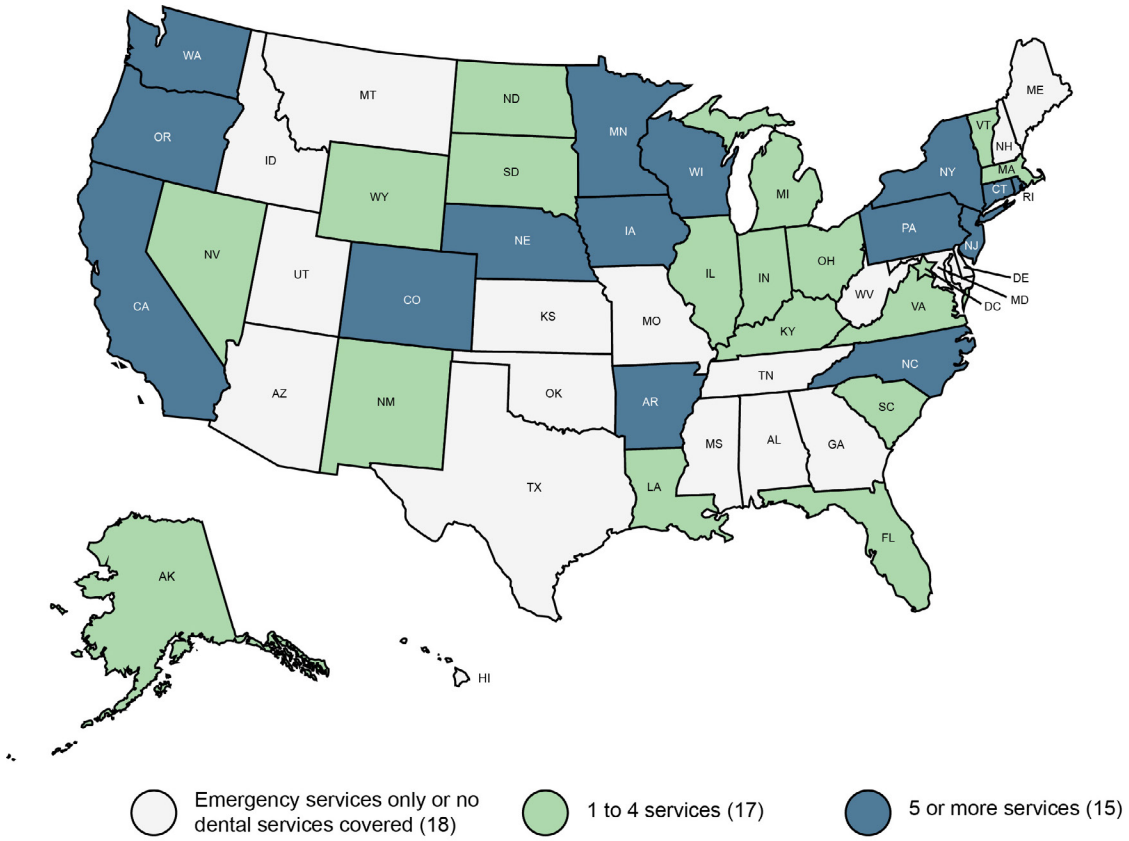
- 18 states only provide emergency dental services to adults;[10] and,
- 33 states provide broader oral health benefits to adults (with annual dollar and service limits).[10]

Among the 33 states providing broader oral health benefits:[10]

- 28 states provide coverage for preventive services (e.g., oral exams, teeth cleanings, fluoride treatment);[10] and,
- 26 states provide coverage for restorative services (with annual service limits).[10]

Additionally, some states provide different oral health benefits to specific populations (e.g., pregnant women, disabled) through Section 1115 waivers.

Figure 1. Medicaid Oral health benefits for Non-Pregnant, Non-Disabled Adults, 2015



Source: Medicaid and CHIP Payment and Access Commission. (June 2015). Chapter 2 Medicaid Coverage of Dental Benefits for Adults in Report to Congress on Medicaid and CHIP. Retrieved from https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

Similar to oral health benefits for children enrolled in CHIP, further variation exists depending on a patient's source of eligibility - traditional Medicaid or Medicaid expansion. Under Medicaid expansion, states are required to select an alternative benefit plan for newly eligible adults that may be different than the benefits offered to adults eligible for traditional Medicaid benefits (e.g., pregnant women, disabled) (see Figure 2).[11] According to an analysis conducted by the ADA, 9.4 million adults were expected to gain access to oral health services as a result of the ACA, through Medicaid expansion and the woodwork effect.[12] Of the 9.4 million, 2.7 million adults were expected to receive extensive oral health benefits and 4.9 million limited oral health benefits.[12]

Figure 2. State Medicaid Coverage of Adult Oral Health Benefits by Type of Beneficiary Population (Traditional or Expansion)

Oral Health Benefits Category	Offered Traditional Medicaid Population	Offered to Medicaid Expansion Population
No oral health benefits	(4) AL, AZ, DE, TN	(4) AZ, DE, MT, ND
Emergency-Only	(13) FL, GA, **HI**, ID, ME, **MD**, MS, **NV**, **NH**, OK, TX, UT, and **WV**	(5) HI, MD, NV, NH, WV
Limited*	(19) **AR**, **CO**, **DC**, **IL**, **IN**, KS, **KY**, LA, **MI**, **MN**, MO, **MT**, NE, **PA**, SC, SD, **VT**, VA, and WY	(10) AR, CO, DC, IL, IN, KY, MI, MN, PA, and VT
Extensive†	(15) **AK**, **CA**, **CT**, **IA**, **MA**, **NJ**, **NM**, **NY**, NC, **ND**, **OH**, **OR**, **RI**, **WA**, and WI	(12) AK, CA, CT, IA, MA, NJ, NM, NY, OH, OR, RI, and WA

Source: Center for Health Care Strategies, Inc. (February 2014). Strategies to Improve Dental Benefits for the Medicaid Expansion Population. Retrieved from http://www.chcs.org/media/CHCS-Revised-Adult-Dental-Benefits-Brief__021214.pdf.
Notes: Bolded states elected to expand Medicaid eligibility under the Affordable Care Act (ACA) as of 2014. Montana and North Dakota offer a different scope of benefits for traditional and expansion Medicaid populations. Idaho provide pregnant women and adults with disabilities with limited oral health benefits beyond emergency oral health care. Maryland MCOs provide coverage for limited adult oral health benefits for their enrollees.

Coverage of Oral Health Services for Pregnant Women

A mother's oral health status (both pre-conception and prenatal) is significantly associated with birth outcomes and the health of her child.[13] In fact, poor oral health like untreated periodontal disease is associated with negative birth outcomes, including preterm birth, low birthweight, and gestational diabetes.[14,15] Additionally, physiological changes during pregnancy can contribute to periodontal diseases like pregnancy gingivitis, dental caries, and tooth erosion.[16] Periodontal diseases during pregnancy disproportionally impact African American women and low-income women enrolled in public assistance programs (e.g., Women, Infants, and Children (WIC), Medicaid), populations that are the least likely to access oral health services during pregnancy.[16]

While pregnant women enrolled in Medicaid and CHIP are entitled to "pregnancy-related services," oral care is not a required pregnancy-related service.[17] Pregnancy-related services are those that provide "treatment of conditions or complications that exist or are exacerbated because of the pregnancy" and are necessary for the "diagnosis, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus."[17] Unless a Medicaid-eligible pregnant women is living in a state that restricts adult oral health coverage for Medicaid enrollees, a state Medicaid program may potentially provide coverage for oral health services for those conditions impacting pregnancy.[17]

* Extensive oral health benefits are defined as "a comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA" and/or "per-person annual expenditure cap is at least $1,000."
† Limited dental health benefits are defined as "fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the ADA" and/or "per-person annual expenditures for care are $1,000 or less."

Disparities in Adult Oral Health Care

The disparities observed in the pediatric population are present in the adult Medicaid population, especially among the very poor and African Americans.[10]

- Roughly 92 percent of adults between the ages of 20 and 64 have cavities.[18]
- Adults with incomes below 100 percent FPL are more than three times as likely to have untreated cavities than those with incomes above 400 percent FPL.[4]
- Of the adults with incomes below 100 percent FPL, 53 percent of African American adults have cavities, compared to 40 percent of non-Hispanic white adults.[19]
- Disparate populations, including special needs and long-term care adults, exhibit significantly greater oral health issues and experience barriers in access to appropriate care.

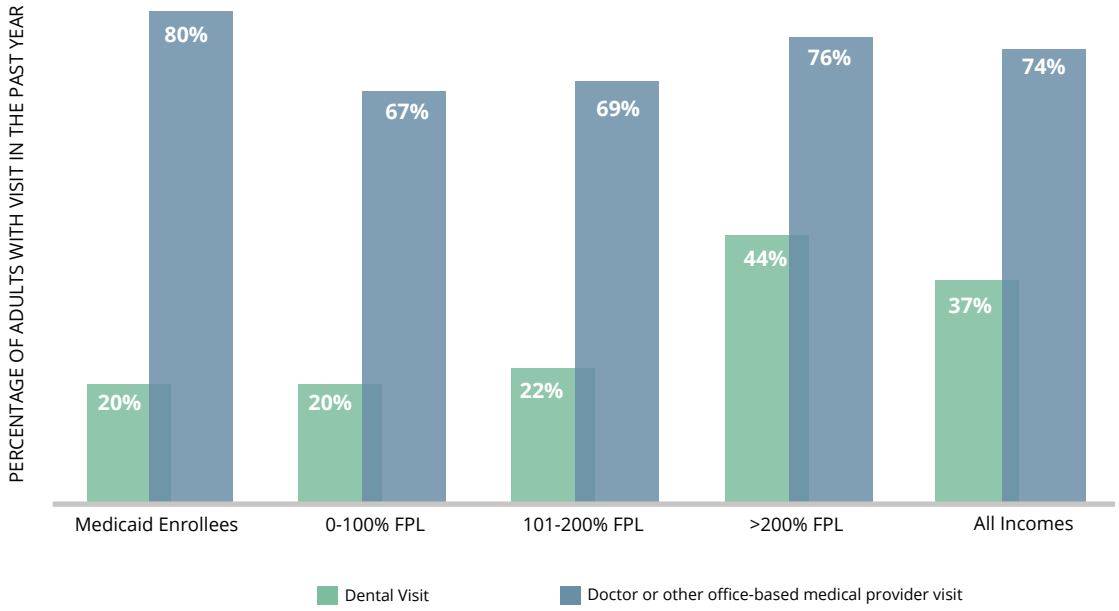
As a result, policymakers focused on reducing the impact of poor oral health on the adult Medicaid population must consider these disparities when designing adult oral health benefits. It is worth noting, the complexity of scope and breadth of oral health services is compounded by the type of delivery system utilized. Adults enrolled in Medicaid managed care plans may receive more robust benefits than those enrolled in fee-for-service (FFS) Medicaid.

Similar to utilization patterns of oral health services in the pediatric population, data indicates that adult oral health benefits are underutilized and declining.

- ADA's analysis of Medicaid-eligible adults and children found that utilization of adult oral health services fell from 54 percent to 48 percent between 2002 and 2010.[2]
  - Only two states experienced a statistically significant increase in utilization from 2002 to 2010, Massachusetts and Virginia.[2] During this time period, 19 states experienced a statistically significant decline in utilization.[2]

- MACPAC analysis of Medical Expenditure Panel Survey (MEPS) data found that 20 percent of Medicaid-eligible adults reported an oral health visit in 2012, whereas 80 percent reported at least one office visit to a medical provider (Figure 3).[10]

Figure 3. Percentage of Adults Age 21 and Older Who Had an Oral Health Visit Versus Doctor or Other Office-Based Medical Provider Visit in Past Year, 2012



Source: Medicaid and CHIP Payment and Access Commission. (June 2015). Chapter 2 Medicaid Coverage of Dental Benefits for Adults in Report to Congress on Medicaid and CHIP. Retrieved from https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

Declining utilization rates among Medicaid-eligible adults are likely due to budgetary pressures resulting in the reduction or elimination of benefits, a phenomenon widely experienced by state governments in the past decade.[1,2,4,10] The reduction or elimination of benefits commonly leads to unmet oral health care needs as low-income adults are unlikely to afford standalone dental coverage through the health insurance exchange or the private market.[2,4,10] Common challenges cited related to access and utilization of oral health services in the adult population include:[1,10]

- Lack of awareness of oral health benefits;
- Gaps in oral health literacy;
- Insufficient enrollment of oral health providers in a state's Medicaid program;
- Lack of available oral health providers within neighborhoods; and,
- Lack of transportation to oral health providers.

Oral Health Integration – Patient-Centered Care

Untreated oral disease can have serious adverse medical implications. Oral health issues have historically been treated as separate entities, apart from the body as a whole. Current research now associates a link between chronic oral infections and diabetes, heart and lung disease, stroke, and poor birth outcomes.[20] Adults with consistent periodontal maintenance regimes have better diabetic outcomes with lowered A1c levels for up to three months. Loss of adult oral health benefits in many States has resulted in driving up emergency department (ED) costs for non-traumatic oral issues. These visits are not only costly to the medical component of Medicaid services, but rarely offer more than short term palliative relief, resulting in a cyclical pattern of ED visits for many adults.

Oral health problems can also interfere with work; employed adults are estimated to lose more than 164 million hours of work each year due to oral health problems or oral health visits.[21] Adults who work in lower-paying industries, such as customer service, lose two to four times more work hours due to oral health-related issues than adults who have professional positions.[20] Visibly damaged teeth or tooth loss can also harm job prospects for adults seeking work.[20] These adverse economic and medical implications, are particularly impactful for low-income, Medicaid-eligible children and adults who may stand to benefit from integrated, patient-centered care that includes oral health services.

Clinical Priorities

Educate pediatricians on the value of pediatric dental homes.

Pediatricians should be educated on the value of the pediatric dental home model and actively encourage parents of Medicaid-eligible children to take their children for their first oral health exam by the child's first birthday. Are MCOs using care coordinators to encourage participation in dental homes? Are MCOs providing pediatric providers with educational materials for parents about pediatric dental homes? Are MCOs engaging in other educational opportunities that promote dental homes for pediatric providers?

Research Priorities

Impact of variation in oral health benefits on Medicaid beneficiaries.

Oral health benefits, for both pediatric and adult populations, vary from state-to-state. How does this variability impact quality and health outcomes for Medicaid beneficiaries, especially those enrolled in MCOs with a multistate presence?

Impact of MCOs in expanding access and utilization of oral health care services.

While some states do not provide oral health benefits for adults, Medicaid MCOs may still provide these benefits for their members. What is the impact of MCO provision of oral health benefits in expanding access and utilization of oral health care in the Medicaid population? Is there a medical cost savings to MCOs by treat oral health conditions?

Stratify impact of adult oral health care by delivery system.

Oral health benefits for the adult population may be provided through FFS, managed care, and managed FFS. How have different delivery systems for adult oral health care impacted access, utilization, and health outcomes? Is there a delivery system that performs best among these areas?

Impact of increased access to oral health care services on outcomes.

Some studies identifying the positive impact of oral health care on prevention and maintenance of chronic conditions. Given the effect of Medicaid expansion and the woodwork effect, how have health outcomes (e.g., heart disease, diabetes) been impacted by increased access and utilization of oral health care services?

Impact of churn on utilization of oral health care services.

Medicaid beneficiaries commonly experience a change in eligibility throughout a benefit year as their incomes are subject to fluctuation. How does the cycle of churn effect utilization of oral health care services among individuals enrolled in Medicaid MCOs? How does this effect the consistency, continuity and quality of care long term for beneficiaries?

Incentivizing utilization of oral health care services.

Research indicates that while pediatric and adult oral health benefits may be covered, they are not always utilized for a number of reasons. What are Medicaid MCOs doing to incentivize use of preventive and restorative benefits among their members? What are the best practices for incentivizing? To improve utilization, should the model consist of incentivizing members or providers? Or a hybrid of both?

Enhancing oral health provider participation in Medicaid managed care.

Research often notes that oral health providers are unlikely to participate in Medicaid programs as a result of insufficient reimbursement rates, administrative burden with filing claims, and a lack of incentive to practice in rural areas. In what way are MCOs providing assistance to oral health providers to enhance participation in the Medicaid managed care program? Are MCOs reducing barriers that delay care? How do provider incentives improve outcomes? Can value based models, as used in medicine, be applied to oral health outcomes? How do state scope of practice laws influence delivery and utilization of oral health services?

Policy and Advocacy Priorities

Reduce variation in pediatric oral health benefits.

Variation in the pediatric oral health benefits between the Medicaid expansion and separate CHIP programs create disparities in coverage within states, especially for those where separate CHIP programs have not been transitioned into Medicaid. Standards of coverage for the pediatric population could reduce this variation.

Make oral health benefits a mandatory benefit for adults in Medicaid.

Currently, adult oral health benefits are an optional benefit, left up to the discretion of the state. As such, coverage for adults is widely variable, ranging in some states from only emergency dental to more robust coverage of preventive and restorative services in others. By making oral health services a mandatory benefit with minimum coverage standards, more Medicaid-eligible adults will have access to oral health care.

Offer enhanced reimbursement rates for oral health providers and expand oral health providers to include dental hygienists, expanded function or advanced practice practitioners, mid-level providers.

In 2013 and 2014, Medicaid provided enhanced reimbursement rates for primary care providers to increase provider participation during the early years of Medicaid expansion. Given the widespread lack of participation of oral health providers in Medicaid, enhanced reimbursement rates should be offered to promote participation in the program. Additionally, by expanding scope of practice for oral health providers to include providers like dental hygienists, states may be able to maximize access to oral health services.

Educate Medicaid beneficiaries about existing oral health benefits and benefits of good oral health.

Studies suggests that Medicaid beneficiaries may not be aware that oral health care is a covered benefit. State Medicaid agencies and Medicaid MCOs are well-positioned to provide parents of Medicaid-eligible children and Medicaid-eligible adults with information about their oral health benefits, how to access them, and provide education on the impact of good oral health on overall health.

Appendix A: Medicaid Oral Health Benefits for Non-Pregnant, Non-Disabled Adults by State, as of February 2015

State	Oral Health Services Covered							Limits	
	Emergency Services Only	Preventive Services	Restorative Services	Periodontal Services	Dentures	Oral Surgery Services	Orthodontia	Annual Spending Limits	Annual or Lifetime Limits on Services
Total	18	28	26	19	26	25	2	9	31
AL									
AK		✓	✓		✓			$1150	
AZ	✓								
AR		✓	✓	✓	✓	✓		$500	Yes
CA		✓	✓	✓	✓	✓		$1800	Yes
CO		✓	✓	✓	✓	✓		$1000	Yes
CT		✓	✓	✓	✓	✓			
DE									
DC		✓	✓	✓	✓	✓	✓		Yes
FL					✓				Yes
GA	✓								
HI	✓								
ID	✓								
IL			✓		✓	✓			Yes
IN		✓							Yes
IA		✓	✓	✓	✓	✓			Yes
KS	✓								
KY		✓		✓					Yes
LA					✓				Yes

State	Oral Health Services Covered							Limits	
	Emergency Services Only	Preventive Services	Restorative Services	Periodontal Services	Dentures	Oral Surgery Services	Orthodontia	Annual Spending Limits	Annual or Lifetime Limits on Services
Total	18	28	26	19	26	25	2	9	31
ME	✓								
MD	✓								
MA		✓	✓		✓	✓			Yes
MI		✓							Yes
MN		✓	✓	✓	✓	✓			Yes
MS	✓							$2500	
MO	✓								
MT	✓								
NE		✓	✓	✓	✓	✓		$1000	Yes
NV					✓				Yes
NH	✓								
NJ		✓	✓	✓	✓	✓			Yes
NM		✓	✓	✓		✓			Yes
NY		✓	✓	✓	✓	✓			Yes
NC		✓	✓	✓	✓	✓			Yes
ND		✓	✓	✓	✓	✓			Yes
OH		✓	✓		✓	✓			Yes
OK	✓								
OR		✓	✓		✓	✓	✓		Yes
PA		✓	✓	✓	✓	✓			
RI		✓	✓	✓	✓	✓			

State	Oral Health Services Covered							Limits	
	Emergency Services Only	Preventive Services	Restorative Services	Periodontal Services	Dentures	Oral Surgery Services	Orthodontia	Annual Spending Limits	Annual or Lifetime Limits on Services
Total	18	28	26	19	26	25	2	9	31
SC		✓	✓			✓			
SD		✓	✓		✓	✓			
TN									
TX	✓								
UT	✓								
VA						✓			
VT		✓	✓	✓		✓		$510	Yes
WA									
WI		✓	✓	✓	✓	✓			Yes
WV	✓								
WY		✓	✓		✓	✓			Yes

Source: Medicaid and CHIP Payment and Access Commission. (June 2015). Chapter 2 Medicaid Coverage of Dental Benefits for Adults in Report to Congress on Medicaid and CHIP. Retrieved from https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

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Reviewers

Prior to publication of the final issue brief, the Institute for Medicaid Innovation sought input from independent clinical, scientific, and policy experts as peer reviewers who do not have any financial conflicts of interest. However, the conclusions and synthesis of information presented in this issue brief do not necessarily represent the views of individual peer reviewers or their organizational affiliation(s).

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