HEALTH POLICY: THE FINE LINE

Dental Benefits Under Medicaid

Earlier this year, a 12-year-old boy from Prince George's County, Md., died because of an untreated dental infection—a lack of care attributed in part to socioeconomic standing and insurance status. This child had been on and off Medicaid. Can you clarify the dental benefits offered under Medicaid, and highlight the obstacles these children face in getting appropriate dental care?

BY BRYAN R. FINE, M.D., M.P.H.

Deamonte Driver, the Maryland youngster who died, actually had far fewer dental travails than his younger brother. His brother DaShawn, 10, was the one who described constant tooth pain to his mother and the one who had several documented oral abscesses. Securing dental services under a dark cloud of homelessness and intermittent Medicaid coverage had been an ongoing problem for the family, even before Deamonte came home one day complaining of a headache. He died a few weeks later, according to the county coroner, from a combination of meningoencephalitis and subdural empyema, the result of an untreated dental abscess.

I have pulled the purported facts of this case from a Feb. 28 story in the Washington Post. I will assume these basic facts are true. My goal here is not to investigate the intricacies of right or wrong, nor to take this individual case and assign personal or systemwide blame. Rather, I would like to use this awful occurrence to highlight general issues that can help us, as pediatricians, treat patients better.

Several questions arise. First, it is important to know exactly what dental benefits are offered to children who are enrolled in Medicaid.

Under Medicaid, and in particular as part of the benefits guaranteed by the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT), low-income children under the age of 19 are entitled to dental screening and treatment—by a dentist. Oral screens by pediatricians are not considered sufficient. Screening must be provided at reasonable intervals, as determined by individual states in consultation with dental organizations.

Federal law requires that, at a very minimum, states cover pain and infection, restoration of teeth, and maintenance of healthy teeth. Anything discovered during screening must be treated appropriately.

The EPSDT coverage is exceptionally generous compared with the private insurance world, where separate dental insurance must be obtained and benefits can vary widely.

With these federally established protections in place, how then do Medicaid children fall through?

Socioeconomic barriers certainly exist, such as availability or affordability of transportation to appointments. A bigger problem though, and an issue that pediatricians also struggle with, is availability of and access to services.

Treating Medicaid pediatric patients is often not profitable for dentists; thus, finding a dentist who treats the Medicaid population can be a real challenge for families who face so may other life obstacles. Routine checkups can easily be pushed off as low priority. Perhaps even a few among us have forgone the routine dental checkup here and there.

Should a severe problem be identified—one that requires surgical intervention, for example—finding a subspecialist who accepts Medicaid, such as an oral surgeon, is even more daunting. Doing so in a timely fashion is nearly impossible. The end result is emergency room visits and extraordinary medical bills.

Deamonte Driver's fatal infection, which could almost certainly have been prevented with a few hundred dollars' worth of dental care, resulted in over $200,000 worth of emergency brain surgery and hospitalization.

Finally, what about the child who falls on and off the Medicaid rolls? In this particular case, it is reported that the family had fallen off Medicaid unexpectedly—the paperwork for reapplication may have been sent to the wrong address amidst transient homelessness—and they had had to cancel a long-awaited appointment with an oral surgeon for the younger boy.

This remains a looming, larger issue of dental and medical consequence, as the protected benefits are rendered meaningless if enrollment is not ensured and somehow protected.

So, what can pediatricians do to help prevent such a situation? From a legislative scope, we need to continue efforts to ease Medicaid enrollment and reenrollment. We need to support EPSDT as the benefit package for children. We need to encourage states to ensure that enough providers—medical and dental—accept Medicaid so that access to care is less of an issue.

We also need to educate families to take personal responsibility for their health, including dental wellness. Sure, part of our screening can be to ask about tooth pains, and exams can include visualization of the teeth and gums. But we should have a list of names of nearby dentists or clinics that accept Medicaid and convince parents that such a visit is not optional. ■

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Primary Care Role Urged as Caries Rise in 2- to 5-Year-Olds

BY KATHRYN DEMOTT
Senior Editor

A significant increase in the prevalence rates of dental caries in the primary teeth of children aged 2-5 years has experts urging primary care providers to reevaluate their role in preventing such outcomes.

In 1988-1994, 24% of children aged 2-5 years had dental caries in their primary teeth. By 1999-2004, that rate had edged up to 28%, according to a report from the Centers for Disease Control and Prevention.

The population sample from the CDC's National Center for Health Statistics involved more than 52,000 participants, aged 2-75 years and older. All of the participants had oral health exams, and they or their parents, in the case of children, underwent home interviews. About half of the group was assessed during 1988-1994; the other half was assessed during 1999-2004.

"It's not a surprise at all," that the dental decay rates are going up among the youngest age set, said Dr. Alan B. Douglass, associate director of the family practice residency program at Middlesex Hospital, in Middletown, Conn. Eighty percent of dental disease clusters in the 20% of children who are at high risk for the disease because they are from low-income families. "It's the access to care issue that's the driver. We are seeing more dental decay because these high-risk kids are having trouble getting access to care."

In many states, Medicaid reimburses dentists less than the cost of delivering care, which tends to involve high overhead because of the instruments required, Dr. Douglass explained.

Through hearings, such as those in Congress earlier this month, and with several legislative efforts at the state level, advocates hope to achieve parity for dental care under Medicaid.

But until better access is achieved, "It's incumbent upon family physicians to get involved," Dr. Douglass urged. "They and other primary pediatric care providers are the only medical professionals who are seeing kids when the disease starts," which in many cases is as soon as teeth start to erupt at 6 to 9 months of age.

Dental disease already has set in by the time a child is 2 years old, by which point "family physicians and other primary pediatric providers have seen these kids at least 7 or 8 times," noted Dr. Russell Maier, program director of Central Washington Family Medicine Residency in Yakima.

Primary care providers can't treat dental disease once it's there, but they can do a lot to prevent it. At each wellness visit, they need to look at a child's teeth and decide if the individual is in the at-risk group. If the parents' teeth are missing or if they've had a lot of restorative work, that should raise a red flag, Dr. Douglass said.

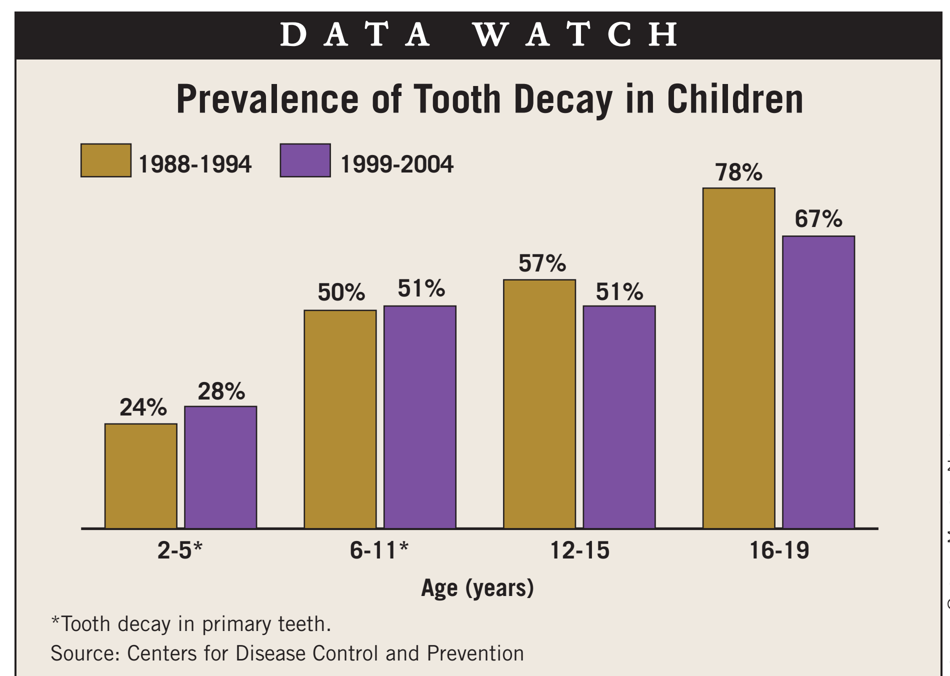
Primary care providers are critical in raising parental awareness about the importance of oral hygiene, diet, and eating patterns, he added.

Moreover, primary care providers are well placed to address the need for flouride and to advocate on behalf of a high-risk patient to ensure that he or she sees a dentist at age 1 year.

Dr. Douglass admits that, in many cases, such advocacy would require "working the system" to overcome poor access to care—there are only about 5,000 pediatric dentists in the United States—and the difficulties in finding a dentist willing to accept Medicaid patients. (See column above.)

Dental disease is the most common unmet pediatric health care need in this country, and yet at the same time "we know what causes it. We know what we need to do to arrest and prevent its complications," Dr. Maier said. ■

DATA WATCH



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