



# Issue Brief:

## Expanding Access to Oral Health Care in Idaho



## Oral Health Is an Important Part of Overall Health and Well-Being

**Oral diseases can be attributed to bacterial infections that, if left untreated, can affect other systems of the body.**

A growing number of studies have found an association between untreated oral disease and other health problems, such as:

- Facial swelling
- Tooth loss
- Poor birth outcomes
- Cardiovascular disease and stroke
- Respiratory infections
- Diabetes
- Deep infection of the face, head, and neck that can be life-threatening.

Oral health is an important marker for overall health status and can impact physical and developmental outcomes, some of which occur early in life. In addition, oral health can have a tremendous effect on daily functioning. Oral diseases can lead to severe pain, poor eating habits, reduced concentration, difficulty speaking, and lower self-esteem. These factors can reduce productivity and compromise performance in the home, at school, and in the workforce.

Dental caries (tooth decay) and periodontal (gum) disease are among the most prevalent and preventable types of infectious diseases, which are caused by high levels of certain bacterial biofilms. These biofilms can find their way into the bloodstream where they can contribute to other systemic conditions (see box).

Even more astounding is that the prevalence appears to be growing – particularly among low-income and racial and ethnic minority populations. This may be attributed to the following:

- The transmissible nature of oral diseases
- A lack of public awareness about the importance of oral health and education on how to better prevent and treat oral disease
- The difficulty that many individuals face in accessing timely and affordable oral health care services

These factors emphasize the importance of implementing prevention and disease management approaches to promote oral health that increase access to education and comprehensive dental care.

***Nearly 51 million school hours and 164 million hours of work are lost annually due to dental-related illness or dental visits.<sup>1,2</sup>***

***Caries is the single most common chronic childhood disease – five times more common than asthma and seven times more common than hay fever.<sup>1</sup>***

***More than 80 percent of all adults experience some form of periodontal disease each year.<sup>3</sup>***

## Many Idahoans Are at High Risk for Poor Oral Health and Inadequate Access to Care

Surveillance data indicates that many Idahoans are at risk for poor oral health outcomes. Moreover, this risk grows over time as significant barriers to accessing care increase with individuals' ages.

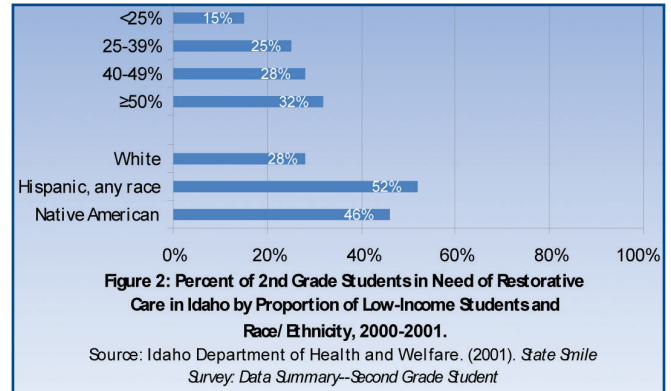
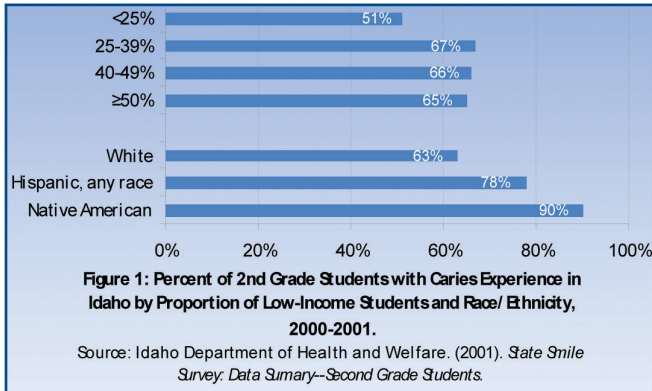
### Perinatal Period

Poor oral health during pregnancy can lead to serious risks to the woman and her developing fetus, including adverse birth outcomes, such as premature birth and low birthweight. In addition, mothers may transmit oral pathogens to their infants shortly after birth. Delivery of oral health not only is safe during pregnancy but can increase the likelihood that children will begin life with good oral health. However, many pregnant women in Idaho are not well-informed about and able to access the oral health services that they need.

- Less than half (44 percent) of women were informed of the importance of dental care during pregnancy from a prenatal care provider in 2005
- Mothers that were uninformed about the importance of dental care were significantly less likely to receive routine dental care during pregnancy (33 percent) than those who were informed (58 percent) in 2005.<sup>4</sup>

## Children and Adolescents

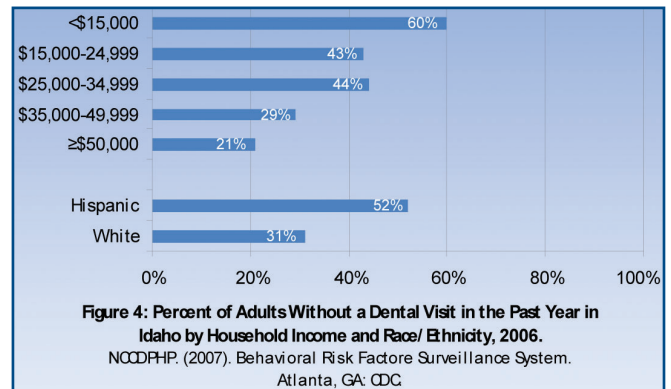
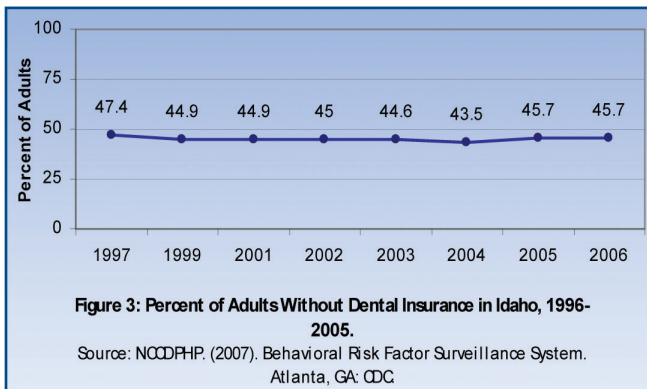
The Idaho State Smile Survey indicates that nearly 70 percent of third-graders had a history of dental caries in 2005. Moreover, the rate of caries experience has increased in all but one health district since the previous statewide survey was conducted in 2001.<sup>5</sup> Although oral disease impacts all populations, some groups suffer a disproportionate disease burden: Nationally, as much as 80 percent of tooth decay occurs in just 25 percent of children. Data from Idaho demonstrate similar trends, the highest rates of caries experience and need for restorative treatment are concentrated among low-income and racial and ethnic minority children (Figures 1 and 2).



## Adults

Although there is no data that measure the prevalence of specific oral diseases among Idaho's adults, available statewide data do indicate that many adults face challenges to accessing and utilizing community oral health services. Nearly one in two Idaho adults lack private or public dental insurance, a trend that has persisted over the past decade (Figure 3).

The percentage of adults without dental insurance is even greater among Hispanic adults (nearly 70 percent) and among adults with the lowest household incomes (70 percent among those earning less than \$15,000, compared to 40 percent for adults earning \$50,000 or more).<sup>6</sup> In addition, more than a third (35 percent) of all adults in Idaho reported that they had not visited a dentist or dental clinic for any reason within the past year in 2006. This proportion is also greatest among adults with the lowest household incomes and among Hispanics (Figure 4).



## Older Adults

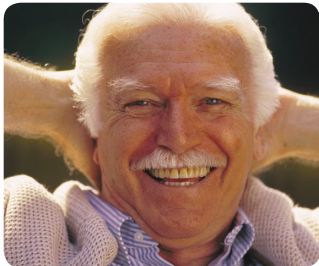
Older adults suffer from the cumulative toll of risk factors for poor oral health over their lifetime, often resulting in extensive oral disease and tooth loss. Of particular concern is that fact that persons 65 years of age and older are seven times more likely to be diagnosed with oral and pharyngeal cancers than younger persons. Relatively few patients survive these cancers, because they tend to be diagnosed at later stages.<sup>7</sup>

**In 2006, 70 percent of Idaho adults age 65 and older did not have any public or private dental insurance.**<sup>5</sup> In addition, Idaho has received a failing grade for the provision of oral health care to older adults (Table 1).

**Table 1: Final Grades for Idaho on National Oral Health Care for Older Americans Report Card, 2003**

Measure	Idaho's Grades
Final Grade	F
Private Dental Insurance Coverage for Older Americans	F
Adult Medicaid Overall	D
Level of Adult Dental Medicaid Coverage	C
Adult Medicaid Service Reimbursement Rates	F

Source: Oral Health America. (2003). *A State of Decay: The Oral Health of Older Americans*. Chicago: Oral Health America.



## Public Programs in Idaho Are Growing, but Still Serve Only a Fraction of the State's High-Risk Population

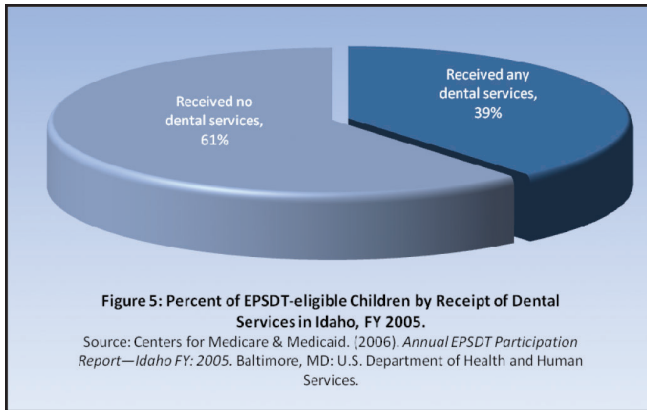
Public programs play an important role in making oral health services affordable and accessible to children and adults in Idaho. Unfortunately, many of these programs have to overcome substantial workforce and financial barriers within the state's oral health infrastructure. The following section provides a brief overview of the successes of and challenges faced by public programs in meeting the oral health needs of Idahoans.

### Medicaid

Although the total number of clients enrolled in Medicaid has increased nearly 50 percent from 2000 to 2006,<sup>8</sup> it is estimated that upwards of 47 percent of the nearly 54,000 uninsured children in Idaho are eligible but not currently enrolled in a Medicaid plan.<sup>9</sup> Dentist enrollment in Medicaid also presents a mixed picture. While almost all of the 807 dentists licensed by Idaho in FY 2005 were enrolled in Medicaid, active participation in Medicaid was much lower:

- Only 70 percent of Medicaid-enrolled dentists (563) actually billed Medicaid with at least one paid claim.
- An even smaller proportion (40 percent) billed more than \$10,000 worth of claims to Medicaid.<sup>10</sup>

Oral health benefits are most comprehensive under Medicaid's Early Periodic Screening, Diagnosis and Treatment Program, which requires the provision of preventive, restorative, and emergency dental services for children. However, the majority of Medicaid-enrolled children in Idaho do not receive these services (Figure 5). Young children are the least likely to receive needed oral health care: **Children ages 1–5 were three times less likely to receive any dental services as those ages 6–20 in FY 2005.**<sup>11</sup>



Active participation in Medicaid is greatly influenced by reimbursement rates available to enrolled dentists. Recent data on Usual, Customary and Reasonable (UCR) fee percentiles provide important insight into how Medicaid’s current reimbursement levels compare to fees typically charged by Idaho’s dentists.

Generally, reimbursement is

at much lower percentiles than the prevailing fees charged by the dental market. While the American Dental Association recommends that fees should approach the 75th percentile or higher to encourage significant dentist participation in Medicaid, Idaho’s fee percentiles are at the lowest levels across a number of commonly used pediatric dental procedures compared to other states in the region (Table 2).

### A Snapshot of Idaho’s Current Oral Health Infrastructure

- The percentage of Idaho’s total population lacking access to dental care is twice the national average (19 percent versus 9 percent).
- More than 90 percent of Idaho is designated as a dental health professions shortage area.
- Nearly 20 percent of dentists are approaching retirement age.
- Dentists are retiring at a faster rate than students are graduating from dental schools.
- Idaho ranks second in the Nation for percentage of personal health care expenses spent on dental care.<sup>11</sup>

**Table 2: Comparison of Mountain States’ Medicaid Payment Rates with Regional Fees**

Procedure Code and Description	ID 2002 Medicaid Rates	Mountain Region* 2001 Average Fees	ID Medicaid vs. Mountain Region Fees (percentile)
<b>Diagnostic</b>			
D0120 – Periodic Oral Exam	\$17.00	\$29.61	4th
D0210 – Complete X-rays, with Bitewings	\$53.00	\$78.38	6th
<b>Preventive</b>			
D1120 – Prophylaxis (cleaning)-Child	\$28.00	\$41.45	3rd
D1351 – Dental Sealant	\$20.00	\$29.57	10th
<b>Restorative</b>			
D2150 – Amalgam, 2 surfaces, permanent tooth	\$55.00	\$95.44	3rd
D2751 – Crown, porcelain fused to base metal	\$318.00	\$612.78	<2nd
*Mountain Region includes AZ, CO, ID, MT, NV, NM, UT, WY Source: American Dental Association. (2004). <i>Medicaid Reimbursement for Mountain Region—Marketplace Principles to Increase Access to Dental Services</i> . Chicago: American Dental Association.			

### Head Start/Early Head Start

Head Start and Early Head Start programs are mandated to ensure that all enrolled children receive an oral health examination, follow-up treatment, oral health education, and a dental home (an ongoing source of care) by the end of the program year. However, only a small proportion of eligible children in Idaho are enrolled in these important early child care and education programs – only 34 percent of eligible 3- and 4-year-olds participated in Head Start services in Idaho in 2006–2007.<sup>11</sup> In addition, a statewide forum convened in 2004 identified a number of barriers to meeting oral health care mandates across Idaho’s 13 Head Start and Early Head Start programs:

### The Idaho Oral Health Program faces a number of barriers to expanding activities.

- Due to limited funding, the **School Dental Sealant Project** only reaches 3 percent of Idaho schools meeting eligibility criteria<sup>17</sup>
- A lack of knowledge about the importance of children's oral health has prevented the participation of some schools in the **School Fluoride Mouthrinse Program**<sup>18</sup>
- The impact of the **Idaho Oral Health Project for Pregnant Women** is limited by challenges to accessing affordable dental care:
  - About half (51 percent) of women that did not receive dental care during pregnancy in 2005 reported that insufficient money or insurance was the primary reason<sup>4</sup>
  - Women on Medicaid were 2.3 times less likely than those on private insurance to receive dental care during pregnancy in 2005<sup>4</sup>

- A shortage of pediatric dentists in rural areas and reluctance among general dentists to see younger children under age 5
- A limited number of dentists that accept Medicaid patients due to low reimbursement rates
- Difficulty experienced by parents and enrolled pregnant women in qualifying for Medicaid dental coverage
- Lack of financial resources for dental care among uninsured children and pregnant women
- Lack of financial and educational oral health resources for Latino families, particularly for those with Limited English proficiency and those that are undocumented<sup>12</sup>

### Idaho Oral Health Program

The goal of the Idaho Oral Health Program is to reduce the proportion of children who experience tooth decay by increasing early access to preventive care through several major school-based programs and a number of special projects, including the following:

- **School Dental Sealants Project** – Targets second- and third-grade students in schools with 50 percent or more of students on the free/reduced-cost meal program.
  - Dental sealants have been shown to reduce tooth decay by more than 70 percent in children.<sup>2</sup>
  - The number of children that received dental sealants through the Sealants Project increased 85 percent since 2001 to 861 in 2005.<sup>13</sup>
- **School Fluoride Mouthrinse Program** – Targets children in grades 1–6 in communities with suboptimal water fluoride levels and in schools with 30 percent or more students on the free/reduced-cost meal program.<sup>13</sup>
  - The Mouthrinse Program prevents one cavity per year for every two children in the program<sup>14</sup> and has yielded estimated annual cost savings of over \$700,000.<sup>13</sup>
  - In 2006, 160 schools participated and 34,812 students received weekly fluoride mouthrinses.<sup>13</sup>
- **Idaho Oral Health Project for Pregnant Women** – Educates pregnant women about the importance of dental care during pregnancy and refers those with oral health risk factors or untreated dental disease for services.
  - The proportion of pregnant women that received dental care during pregnancy has increased from 38 percent in 2001 to 44 percent in 2005.<sup>13</sup>
- **Early Childhood Caries (ECC) Prevention Project** – Targets high-risk, low-income children aged 0–5 years and is conducted in partnership with the Idaho Women, Infants, and Children Program (WIC) and Head Start programs. Services include screenings, oral health education, and fluoride varnish application.
  - The number of children that received fluoride varnish through the ECC Prevention Project increased 80 percent since 2001 to 2,951 in 2005.<sup>13</sup>

## Recommendations to Improve Access to Oral Health Care in Idaho

### ① *Re-establish Idaho's State Dental Director position*

Idaho's State Dental Director position is currently vacant. Filling this position is critical to providing leadership for the public health and Medicaid oral health programs in the State. Key duties of this position should include raising public awareness about the importance of oral health, providing oversight for public oral health programs, developing and implementing policy, and collaborating with public and private partners to conduct major health district activities such as oral health surveillance, needs assessments, and provision of education and training opportunities.

### ② *Provide outreach and training to community providers*

Many medical providers have not received extensive training on how to recognize and address patients' oral health needs as part of their clinical practice, particularly among their perinatal, pediatric, and geriatric populations. Similarly, many general dentists may lack specialized education and skills necessary to care for these groups. The establishment of training programs for providers can help address such knowledge deficiencies. In addition, intensive recruitment efforts can also encourage more dental providers to serve high-risk populations and to increase their level of active participation in Medicaid.

### ③ *Expand enrollment in existing public oral health services*

A significant number of children and adults that meet eligibility criteria for publicly funded oral health services are not currently connected to these resources. There is an opportunity to increase outreach and the level of enrollment in oral health services offered by programs such as the Idaho Oral Health Program, WIC, and Head Start/Early Head Start. To ensure an adequate level of care, these programs will require a greater level of funding and staffing to support higher enrollment levels.

### ④ *Provide greater assistance for the near-poor that do not qualify for public programs*

Access to oral health is especially limited among the near-poor (typically defined as those with incomes at 101–199 percent of the poverty level). Near-poor individuals and families are less likely to qualify for public insurance programs and tend to be overrepresented in low-wage jobs that do not offer comprehensive employer-based dental insurance or any dental benefits at all. Providing additional support to safety net services would greatly improve access to oral health care services for near-poor and uninsured populations, such as to Idaho's federally qualified community health centers and state- or privately-funded community dental clinics. In addition, there is an opportunity to partner with local foundations to establish new pools of funds to help cover the cost of care for groups that are ineligible for public programs.

### ⑤ *Increase Medicaid reimbursement rates to increase dentist participation*

The high level of enrollment in Medicaid by Idaho's private dentists is evidence of their interest in serving low-income populations. However, their active participation in this critical public program has been severely hindered by noncompetitive Medicaid reimbursement rates, which have historically ranked among the lowest in the nation. The Idaho Smiles Program, launched in 2007, was designed to address this issue by offering enhanced reimbursement rates for participating dentists. Yet these enhanced rates represent only a nominal increase, an average of just 6 percent across most included services, and are still too low to adequately cover the direct cost of care and to help cover overhead costs. Idaho's Medicaid fee schedule should be raised to approach the 75th UCR fee percentile or higher to ensure more active participation in Medicaid.



## Endnotes

- 1 U.S. Department of Health and Human Services. (2003). *A National Call to Action to Promote Oral Health*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research (NIH Publication No. 03-5303).
- 2 U.S. Department of Health and Human Services. (2000). *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research.
- 3 National Institute of Dental and Craniofacial Research. (2002). *Periodontal (Gum) Disease: Causes, Symptoms, and Treatments*. Bethesda, MD: National Institutes of Health.
- 4 Idaho Department of Health & Welfare. (2006). *Dental Care During Pregnancy: 2005 Idaho Pregnancy Risk Assessment Tracking System*. Boise: Idaho Department of Health & Welfare, Division of Public Health, Bureau of Healthy Policy and Vital Statistics.
- 5 Idaho Department of Health & Welfare. (2007). *Oral Health in Idaho*. Boise, ID: Idaho Department of Health & Welfare, Division of Health, Oral Health Program.
- 6 National Center for Chronic Disease Prevention and Health Promotion. (2006). Behavioral Risk Factor Surveillance System: Prevalence Data. Retrieved January 15, 2008, from CDC Web site: <http://apps.nccd.cdc.gov/brfss/>.
- 7 Vargas, C.M., Kramarow, E.A., & Yellowitz, J.A. (2001). The Oral Health of Older Americans. *Aging Trends*, No. 3. Hyattsville, MD: National Center for Health Statistics.
- 8 Brown, A. (2008). *Idaho Oral Health Summary: A Call to Action—Summary Report*. Boise: Idaho Oral Health Alliance and the Idaho Department of Health and Welfare.
- 9 Idaho Kids Count. (2007). *State of Idaho: Noteworthy Trends and Statistics*. Boise: Idaho Kids Count.
- 10 Centers for Disease Control and Prevention (CDC). (2006). Idaho – Oral Health Profile. Retrieved February 23, 2008, from CDC Web site: <http://apps.nccd.cdc.gov/nohss/bystate.asp?stateid=16>.
- 11 Centers for Medicare & Medicaid. (2006). *Annual EPSDT Participation Report—Idaho FY: 2005*. Baltimore, MD: U.S. Department of Health and Human Services.
- 12 Idaho Head Start Association. (2005). Idaho Head Start Oral Health Forum: Final Report. Retrieved February 20, 2008, from ASTDD Web site: <http://www.astdd.org/docs/FinalReport.IDHeadStart.02.16.05.pdf>.
- 13 Association of State and Territorial Dental Directors (ASTDD). (2002). Dental Public Health Activities & Practices. Retrieved February 20, 2008, from ASTDD Web site: <http://www.astdd.org/bestpractices/pdf/DES15001IDfmrprogram.pdf>.
- 14 Idaho Department of Health and Welfare (IDHW). (2008). Oral Health. Retrieved February 20, 2008, from IDHW Web site: <http://www.healthandwelfare.idaho.gov/DesktopModules/ArticlesSortable/ArticlesSrtView.aspx?tabID=0&ItemID=435&mid=10560&wversion=Staging>.