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Improving Oral Health Across America

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Millions of Americans suffer from poor oral health with decaying teeth, gum disease and chronic tooth pain. Poor oral health can limit a person's employment opportunities,[1] increase the risk of certain cancers,[2] cardiovascular disease,[3] Alzheimer's disease,[4] premature births[5] and lead to unnecessary emergency department (ED) visits.[6]

Poor oral health can be a result of limited access to preventive dental health sources, among other causes. However, there are a variety of confounding factors that limit access to timely oral health care, including:

- Limited insurance coverage
- Provider shortages, particularly in rural areas
- Cultural barriers

These problems are not distributed evenly. In the U.S., if you live in a rural area, you are less likely to have dental insurance[7] and access to a dentist, and more likely to have tooth loss.[8]

Oral health is a vital component of overall health status. It is vital that people have access to regular dental care to learn good oral hygiene and to treat problems early. This paper will explore barriers to care and potential policy levers to address them.

INTRODUCTION

According to one study, toothaches were the number one avoidable reason[9] for visiting the emergency department (ED). In some instances, patients leave dental issues untreated until they experience so much pain that they visit the ED, desperate for treatment. But EDs are poorly equipped to treat dental conditions and usually simply offer pain medications[10] or antibiotics

and refer patients to dental providers in the community.

LIMITED COVERAGE

Cost is the number one reason[11] people cite for forgoing dental care. More than 114 million Americans lack dental[12] health coverage, roughly four times the number of people who lack regular health insurance. And that number has likely grown considering the 5.4 million people who have lost their insurance[13] during the pandemic. People without dental coverage include almost two-thirds[14] of Medicare enrollees, roughly 10 percent of children[15] and 33.6 percent[16] of adults under the age of 64. But even among those who have dental coverage, it can be a bit of a misnomer. Most plans only cover $750 to $1,500[17] of care per year, requiring patients to pay for additional care out of pocket. While only a small percentage of people exceed this amount each year, a crown can run as high as $2,500,[18] which can surpass even an insured person's coverage.

Though we know that dental coverage is a vital first step to getting people dental care, expanding coverage does not fully solve the issue. The data shows that in states that expanded dental coverage to adults with Medicaid, emergency dental visits remained high, [19] even in urban areas with numerous dentists. This suggests there are other barriers, besides coverage, to accessing care.

Dental care has long been perceived as secondary to medical care. Traditional Medicare does not cover preventive dental services and Medicaid is not required to cover dental benefits for adults (though 35 states provide some dental benefits[20] to adults). The perception that dental care is secondary trickles down to even those with coverage. Many people with dental insurance don't use their benefits until they are in pain.[21]

PROVIDER SHORTAGES.

Poor oral health is not distributed evenly: rural residents are twice[22] as likely to have none of their natural teeth remaining when compared to urban residents. This is because, in some areas of the United States, even if you have dental coverage, you may be hard pressed to find a dentist or a dentist that takes your insurance. While there may not be a shortage of dentists in the United States as a whole, they are poorly distributed – and rural areas often do not receive the resources they need to address oral health challenges. As dental students graduate with more and more student loan debt, many move to urban centers to set up their practices because they will have more privately-insured patients. Thus, there are some rural areas where, even if you did have health insurance that covered oral health services, it may be challenging to find a nearby dentist to serve you. In remote areas with small populations and more people on public health insurance, it can be hard for a dental practice to survive.

To help address this challenge, the Health Resources and Services Administration (HRSA) created the health provider shortage area (HPSA) designation to allocate resources to underserved areas. Specifically, students that chose to practice in HPSAs are eligible for loan repayment and scholarships. Today, more than 30 federal programs[23] allocate resources based on HPSA designations and many states use the definition for state funding as well.

However, due to the way the agency defines dental health shortage areas, shortages and other barriers to accessing care may

be overstated.[24] This means that providers across the nation are forced to compete for limited resources. The program received 7,000 applications in the last cycle and could only award funding to 40 percent[25] of the applicants.

Dental health shortage areas are rated on a point system, 0-26. The higher the score, the greater the level of need in an area. However, certain factors may skew the rating, including the fact that a point is added if an area's fluoridation rate is in the bottom quartile for the nation, region or state. HRSA estimates that one dentist is needed for every 5,000 people (or 4,000 people in very high need areas). Narrowing the factors that allow an area to be classified as a HPSA will help ensure that limited funds get where they are needed most.

Other barriers to care also tend to be under-reported. Many Medicaid-insured adults report trouble finding a dentist that will accept their Medicaid coverage because of their state's low reimbursement rates.[26] While there might be community health centers that are happy to treat Medicaid covered patients, they could have limited availability for appointments and many private practice dentists might limit the number of Medicaid patients they accept. Without assistance navigating the health system, these patients might not get the care they need.

It's important to consider these comprehensive barriers to accessing care in rural areas rather than just looking at the number of dentists in an area.

CULTURAL BARRIERS

Because oral health has long been separated from physical health, some people view it as secondary, and often need help navigating the existing resources and overcoming individual barriers to care. For example, a lack of awareness of dental benefits, how to find a quality dentist and oral health literacy all prevent people from seeking treatment.

States have long acted as the "laboratories of democracy" piloting innovative policy solutions, that if proven successful, can be scaled. Oral health is no different. The federal government has an opportunity to learn from the states and increase access to dental health services.

POLICY SOLUTIONS

Expand coverage and increase reimbursement. Medicaid covers dental benefits for children, but states are not required to cover dental services for adults. If Medicaid took the $520 million that it spends annually on dental ED visits and invested it in upfront oral health services, it would cover roughly one million dental visits.[27] Though all states cover eligible children through Medicaid, coverage for adults is less consistent. Some states cover preventive services[28] for adults, but many only cover emergency dental services. All states should expand Medicaid to cover all low-income adults and cover dental services for adults recognizing that the upfront investment improves health and reduces unnecessary emergency room expenditures.

But Medicaid coverage isn't the only thing limiting access. On average, state Medicaid programs reimburse dentists 40 to 50 percent[29] of what private insurance pays. The low rates limit the number of Medicaid patients that dentists will accept.[30] Increasing reimbursement, particularly in underserved areas with high numbers of Medicaid enrollees, would encourage more dentists to see Medicaid patients.

States should also consider programs that would help people above the Medicaid income threashold afford dental health benefits. The ACA does not require compliant health plans cover dental and many people — particularly those below 300 percent of the federal poverty level — may not be able to afford dental benefits without government subsidies.

Traditional Medicare should also cover preventive dental services rather than forcing patients to buy secondary Medigap plans to get dental benefits. Almost two-thirds of Medicare enrollees[31] don't have dental coverage. There are a variety of conditions that are more likely with old age including edentulism – where a person has no natural teeth. Fifteen percent of seniors are edentulous and it is more likely among older and poorer seniors. Periodontal disease is the most common[32] cause of tooth loss and can be prevented with proper preventive care. Expanding Medicare coverage of dental care can improve the overall health of seniors, particularly among long-income seniors with limited resources to spend on dental care.

Redefine Health Professional Shortage Areas.
According to the GAO, in 2005 more than 30 programs[33] used federal health professional shortage areas (HPSA) designations to allocated funding and resources. But as discussed above, the scoring mechanism might not be the most accurate way to decide what is or isn't a shortage area. Furthermore, HRSA has long used county boundaries[34] to measure provider shortage areas, which can create artificial borders and over estimate the number of people living in shortage areas. Using geo-analysis to calculate the prevalence of dentists is more accurate than using county boundaries.

For these reasons and many more, HRSA is currently accepting ideas[35] on how to best update the health professional shortage area (HPSA) designation. The revised HPSA criteria should be formulated in a way that directs limited resources to the most underserved rural areas and considers all barriers to care.

Address provider shortages in underserved areas.
There are a number of policy initiatives to address provider shortages. Thirty-three states and the District of Columbia provide dental loan repayment[36] to encourage graduating dental students to practice underserved areas. But these programs are slow to address current shortages. In some very remote areas, such as Alaska, where it would take years to recruit dentists to small, isolated communities, policymakers created a two-year training program for "dental health therapists" to help fill in provider gaps. But before more states create these new programs, they need to accurately understand the barriers to access care within their borders. As part of the process of reevaluating the criteria to establish a HPSA, HRSA should use a new methodology to address provider shortages in underserved areas. Rather than simply increasing funding to loan repayment programs, while important, the government needs to better understand and address barriers to clinicians providing care in underserved communities.

Address individual barriers through community outreach and education.
Oftentimes, communities don't need more dentists to address access to care issues, but instead need greater resources to help people with finding and navigating the existing oral health resources and navigating individual

barriers to care. Roughly 80 percent of community health center[37] clinics offer free or discounted dental services to people who need them. Unfortunately, many potential patients often don't know that dental care is readily available at these facilities and delay care until they experience so much pain that they end up at the ED.

States have developed pilots with a new type of health worker: a community dental health coordinator (CDHC). Community dental health coordinators help patients better access dental care and navigate the health care system. Based on the community health worker model, where workers help patients bridge the gap between clinical and community services, CDHCs provide community-based prevention, care coordination and patient navigation to connect people with available services in their community. They can work for health centers, private dental practices and schools to better connect patients with the care they need. They may be able to perform some preventive services such as sealants and fluoride applications, as their state licensing laws allow, but they are not mid-level providers and must work under the supervision of a dentist.

CONCLUSION

This paper outlines the three main barriers to accessing dental care – coverage, dentist shortages and cultural barriers to oral health. There are a variety of ways to address these barriers, but an effective strategy will attempt to address all three. Expanding dental health coverage and increasing reimbursement – particularly in rural areas is a needed first step to improving oral health. HRSA needs to better define dental health professional shortage areas so that limited resources are appropriately targeted to underserved areas. Furthermore, the federal government needs to better understand the dental health workforce and how to better reach underserved populations. Finally, focusing on cultural barriers to care can be a cost-effective way to increase access and improve outcomes.

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