

Medicaid Coverage for Adults in North Carolina: What Would a Reduction in Funding Mean?

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States can achieve short-term cost savings through a reduction in Medicaid adult dental benefits. This article presents an overview of the long-term consequences of a population of disadvantaged adults faced with a greater oral disease burden and the effect of poorer oral health on systemic health and quality of life.

The former US Surgeon General C. Everett Koop once said, "You are not healthy unless you have good oral health" [1]. Despite this sage advice of almost 2 decades ago from one of the leading authorities on health care in the United States, there continues to be growing concern that many disadvantaged citizens in the country lack access to basic oral health care services that can prevent more serious systemic disease. Many research studies have demonstrated links between oral health disease and other chronic medical problems [2-5]. Yet, in the face of this emerging evidence about the importance of oral health, the scope of services offered to the adult Medicaid population in many states continues to shrink. With the economic adversity that some states are facing, a growing number of adult Medicaid beneficiaries in the US who are at risk for oral disease for a variety of reasons (eg, low income, chronic medical co-morbidities, or special health care needs) have emergency only or no coverage whatsoever to prevent minor oral health care problems from becoming major systemic health concerns. Adult Medicaid dental benefits are considered optional services under Title XIX of the Social Security Act [6]. In the last few years, many states have elected to reduce adult Medicaid dental benefits in an effort to achieve short-term cost savings. Oral health policy experts question whether this is a short-sighted approach to balancing state budgets that ignores the long-term costs of state funds spent for emergency room visits and hospitalizations of Medicaid adult recipients secondary to a medical problem of dental origin.

Background

In North Carolina, approximately 750,000 adults who are 21 years of age or older are eligible each year for Medicaid benefits [7]. Of this population, about 45,000 of these adults are "dual eligibles," meaning they are eligible for both Medicare and Medicaid public insurance benefits [8].

Unfortunately, the dual eligible population receives only the minimal dental benefits that are covered under Medicare. The scope of dental services for Medicare recipients is limited to oral surgery services such as extractions in preparation for radiation therapy, reduction of jaw fractures, and removal of tumors of the jaws. [9]. The remainder of the adult population, with few exceptions, has fairly comprehensive coverage which includes basic oral health services including exams; radiographs; cleanings; fillings; root canals on anterior teeth; periodontal procedures like scaling and root planing (deep cleaning) and some limited periodontal surgery procedures; dentures; acrylic partial dentures; extractions of erupted and impacted teeth; and many other oral surgery services, as well as adjunctive services like general anesthesia and intravenous conscious sedation [9].

While the benefit package for adult recipients is not as generous as the amount and type of covered services available to Medicaid eligible children in our state, it is substantially more comprehensive than the scope of services offered by other state Medicaid agencies to adult beneficiaries. This is particularly true when comparisons are made to our neighbors in the other southeastern states [10]. North Carolina has a proud tradition of dental public health dating back to the first state government dental public health program established in 1918 [11]. For decades, the state Medicaid agency, the Division of Medical Assistance, has administered a dental program with a wide range of basic dental services to ensure that the oral health needs of at-risk citizens of North Carolina would not be ignored to the detriment of their systemic health. The North Carolina Medicaid adult dental benefit plan continues to set our state apart from other states, demonstrating the charitable nature of North Carolinians toward underserved individuals in our state. Today's North Carolina dental public health professionals have upheld the proud heritage of their pioneering program by consistently striving to make the public aware that optimal oral health is essential to achieving overall systemic health.

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Most North Carolinians realize that Medicaid is a public insurance program aimed at providing quality health care to low-income adults and children. But beyond the knowledge that the program seeks to meet the health care needs of citizens with low socioeconomic status, it is imperative that the state's taxpayers and policymakers be aware of the other types of individuals in the state's Medicaid population. The adult Medicaid population also includes many individuals with complicated medical problems including diabetes, cancer, HIV, heart disease, and other chronic medical conditions. Nursing home, group home, and other long-term care facility residents make up a substantial proportion of the North Carolina Medicaid beneficiary population. Adults with intellectual, developmental, and physical disabilities are represented in numbers far greater in the Medicaid program than in other private health care insurance plans operating in the state. Over one half of the births in the state are to Medicaid eligible women, [12] the vast majority of whom are in the adult population over age 20. More than 140,000 North Carolinians over age 64 have full Medicaid benefits including the current covered dental services [13]. Clearly, any change to the North Carolina Medicaid adult dental benefit will impact many citizens who are less likely to have the resources to access and pay for timely oral health care and who are much more susceptible to oral disease and its impact on systemic illnesses than other citizens of the state. Thus, it is not difficult to envision how devastating a reduction in adult Medicaid dental services would be to a population of individuals that can least afford to be without basic oral health care services.

The Importance of Maintaining the North Carolina Medicaid Adult Dental Benefit

There are a number of reasons why the North Carolina Medicaid adult dental benefit should be maintained at its current level of services.

Dental care is primary care. Unlike other health care services, oral health care has not historically been a service that has been rendered in a primary care medical practice. Nor have primary care medical providers (PCPs) shown the inclination to expand the oral health care services they offer beyond preventive services to young children. Elimination of or a sharp reduction in North Carolina Medicaid adult dental services may thrust North Carolina physicians into a role with which they are unfamiliar. A good indication of PCPs' lack of understanding of oral health diagnoses is the level of oral health care services that are delivered in hospital emergency departments (EDs). The scope of services in EDs is typically limited to palliative care. Likewise, the diagnostic codes used by hospital staff for dental problems treated in the ED show some evidence that medical staff lack fundamental understanding of oral diagnoses. Many codes used in ED visits for oral health diagnoses are not specific codes, that is, they do not provide detailed descriptions of the problem. This suggests that ED clinicians may be hav-

ing difficulty making a diagnostic decision regarding the true nature of oral health problems. In recent legislation, including the Patient Protection and Affordable Care Act (PPACA), great efforts have been made to promote and preserve primary medical care as the means to better health outcomes and cost savings. Primary oral health care deserves the same sort of protection from potential budget cuts as states formulate strategic plans to pay for the full implementation of PPACA in 2014.

Oral health care rendered in the hospital emergency department This type of care is not only limited, it is also expensive, inefficient, and rarely results in a definitive resolution of the problem. An examination of claims submitted by hospitals for medical problems with a dental diagnosis demonstrates that many times the patient receives an evaluation, diagnostic testing like an enhanced imaging technique (e.g.—radiograph, MRI, CT scan), and prescriptions for an analgesic and an antibiotic. Lack of treatment aimed at removing the root cause of the patient's problem could very likely result in a return visit to the ED if the patient is unable to access care in a dental office. A recent Pew Center on the States study, using primarily Medicaid data, found that publicly insured beneficiaries are turning to hospital emergency rooms for routine dental problems — a choice that can often cost up to 10 times more than preventive care and offers far fewer treatment options than a dentist's office [13]. If the services that general dentists usually perform are no longer covered (routine exams, radiographs, cleanings, and fillings), more dental disease in the reparable stages will go undetected until the pathology becomes an urgent or emergent care problem. A dental abscess can lead to more systemic infections of the adjacent tissues of the head and neck, the bloodstream, and, in a worst-case scenario, may result in death. Preventive and restorative dentistry procedures are a far more cost-efficient means of avoiding more expensive care in the hospital setting. An increase in the number of visits to hospitals by Medicaid recipients with oral health problems will place ED physicians in the unusual position of being forced to render more accurate diagnoses and triage to ensure that larger numbers of Medicaid recipients seeking emergent care for oral health problems in EDs are referred to the appropriate provider.

The effect on safety net dental clinics. Publicly and privately supported clinics like federally qualified health centers, local health departments, and free and reduced-fee dental clinics treat many uninsured North Carolinians. When another estimated 700,000 Medicaid recipients without dental benefits are added to the large number of underserved North Carolinians without dental insurance, it is highly unlikely that the infrastructure currently exists or can be added quickly enough to the safety net provider network to provide even basic oral health needs to the increased uninsured population. Almost certainly, this large influx of patients without dental insurance will dramatically change the practice patterns of public and private safety net providers toward more

urgent/emergent care services. A reduction in, or elimination of, the Medicaid adult dental benefit will likely have a profound effect on another high profile institutional safety net provider—the East Carolina University (ECU) School of Dental Medicine. The state's new dental school plans to open 10 Community Service Learning Centers in underserved areas throughout the state [14]. ECU officials have indicated that the financial health of the dental school depends heavily on maintaining the current comprehensive dental coverage for North Carolina Medicaid adult recipients. The dental school administration's innovative and exhaustively researched strategic plan to improve dental access in North Carolina merits continued support from the legislative and executive branches of state government.

Oral disease and linkages to systemic disease. There is a growing body of research that points to linkages between untreated oral disease, particularly periodontal (gum) disease, and exacerbation of chronic conditions such as diabetes, heart disease, respiratory disease, and stroke. Individuals with these chronic medical conditions have been found to be at higher risk of developing more severe morbidity if they also have been diagnosed with oral inflammatory diseases. For example, a study of Aetna administrative claims data found that privately insured people with advanced gum disease had higher 2-year costs for diabetes, stroke, and heart disease than people with less severe dental conditions. This study found that those with diabetes experienced a 21% lower health risk and 9% lower health care costs with early dental care; those with coronary artery disease experienced a 19% lower risk and 16% lower costs; and those with other cardiovascular diseases experienced 17% lower risk and 11% lower costs [15]. As a result of this study, Aetna extended enhanced dental coverage to pregnant women and people with heart disease. Another study by the Blue Cross Blue Shield of Michigan Foundation investigated whether there is an association between the use of periodontal services and medical care costs for diabetes. It found that adults with diabetes who receive non-surgical periodontal procedures had significantly lower medical care costs than those who did not receive these procedures [16]. These studies provide encouraging evidence that the provision of dental services to adults with some of the most common chronic diseases can not only ameliorate these conditions, but can also save money in the process. Since some oral diseases, such as periodontal disease, are more prevalent in adults, it stands to reason that eliminating or reducing dental benefits in the adult population may lead to a substantial increase in the severity of chronic medical conditions in an insured population that includes a large number of at-risk individuals.

Maternity and newborn care. Several studies have reported finding an association between untreated periodontal disease and the increased risk for preterm delivery and low birth weight babies. Thus, a mother's oral health status is thought to be critical to the health of the most vulnerable among the Medicaid population—newborns. There

is also convincing evidence that dental caries is an infectious disease that is transmitted from caregivers, most often mothers, to infants and toddlers, and that comprehensive oral hygiene measures and preventive care in mothers can significantly reduce the levels of decay-causing bacteria in their children [17].

Adults with special needs. Individuals with intellectual and developmental disabilities and the elderly may have physical, cognitive, or behavioral limitations that impair oral care at home. The chronic and complex health conditions with which adults with special health care needs present with may be adversely affected by oral disease. Many of these special care patients take medication that reduces saliva flow, which is a natural defense against cavity-causing bacteria. Additionally, poor oral health may impair their ability to maintain proper nutrition. As noted previously, the North Carolina Medicaid population has a large number of adults with medical diagnoses, which place them in the special needs category. Without Medicaid dental benefits, a population that already faces significant barriers to accessing care in dental offices will have even more difficulty obtaining oral health care. It is unclear where these individuals will turn for care if they lose their dental benefits.

Disease detection and prevention. Access to regular dental care is not only critical for optimal oral health, it also provides windows of opportunity to detect and diagnose early manifestations of osteoporosis, certain cancers, eating disorders, substance abuse, HIV infection and progression to AIDS, and other systemic health problems. Early detection of these problems by dental professionals results in better health outcomes for Medicaid recipients and lower costs to the Medicaid program.

Quality of life issues. Better oral health enhances Medicaid recipients' ability to obtain and retain jobs. An estimated 164 million work hours are lost each year in the US due to oral health problems [18]. The psychosocial concerns regarding better oral health should not be underestimated. For example, a partially edentulous or edentulous individual seeking a new job will be much more confident during the interview process if their missing teeth are replaced with an aesthetically pleasing and functional prosthesis. Adult Medicaid recipients should have the opportunity for optimal oral health to improve functional capacity—including the ability to speak, chew, maintain proper oral hygiene, and be free of pain, infection, and conditions that cause trauma to oral hard and soft tissues.

Conclusion

There is little doubt that short-term cost savings can be realized by reducing the North Carolina Medicaid adult benefit to emergency services or by eliminating all covered dental services. The more important question is this: what long-term cost are policymakers willing to pay for an action that will undoubtedly lead to increased morbidity among the most vulnerable members of society? All stakeholders

should carefully consider what the future implications will be to the disadvantaged and how these individuals with fewer resources will be able to fill the void that is left when primary oral health care is taken away from them. **NCMJ**

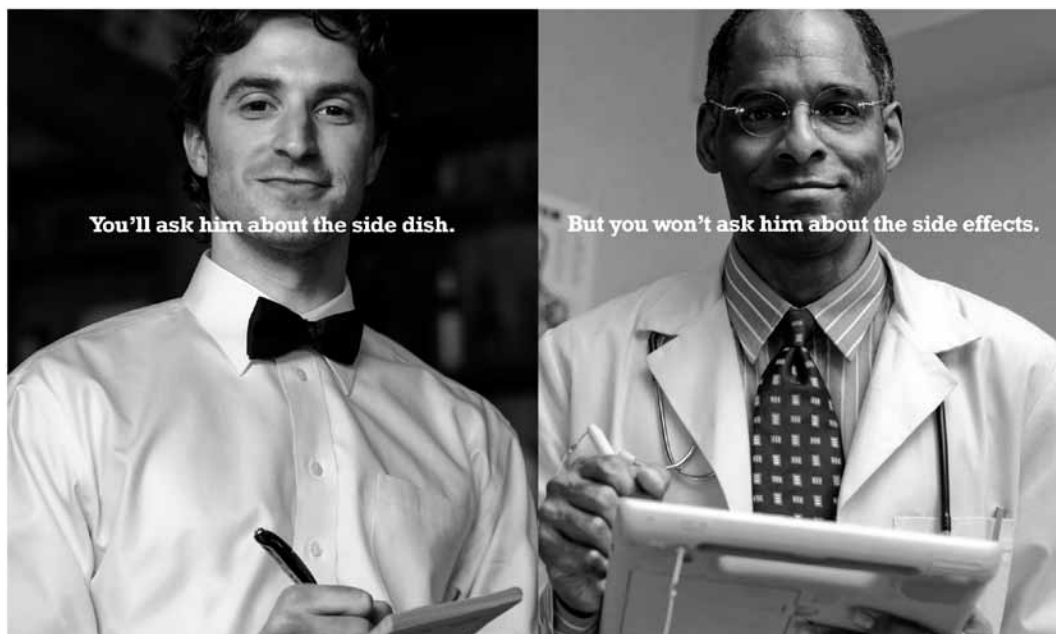
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