Options for Oral Health Care for Children in Poverty in Syracuse, New York

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Background

The U.S. Surgeon General issued a report in 2000 which highlighted the relationship of good oral health to overall good health and documented tooth decay as the most common chronic illness among children[1]. This report also drew attention to the prevalence of poor oral health in low income populations. The Centers for Disease Control and Prevention identified early childhood dental caries as perhaps the most prevalent infectious disease in children in the United States[2]. Untreated, this can result in serious implications for growth, development, school performance and peer relationships[3]. Low income persons, particularly children, face barriers in access to comprehensive oral health care for a variety of reasons, including the structure of the organization and financing of oral and dental health care.

The New York State Oral Health Plan (the Plan), adopted in January, 2007, recognizes the need for improved oral health care for all populations[4]. The Plan singles out children and includes a recommendation, among others, that public resources be focused on application of fluoride varnish to high risk children (under six years of age).

The Community Health Foundation of Western and Central New York (CHFWCNY) convened a group of community leaders interested in and involved with provision of dental and oral health care services to children in the greater Syracuse community, particularly children ages 0-8 living in poverty. The group's initial goal was to identify issues that impact on access to dental care that can be the subject of research to will frame the issues and identify potential strategies that can be considered for implementation to improve access and be integrated into work plans, serving as a community agenda.

This report offers background information to support the group's discussions and will serve as the foundation for the final report containing recommendations for action to improve access to dental care. The report begins with a discussion of recommendations for optimal oral health care in children, reviews barriers to access, outlines the way dental health care is financed, follows with a discussion of some of the issues relevant to the Syracuse community and raises some questions about how to improve access to oral health care for the children in poverty in our community.

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[1] Kaiser Commission on Medicaid and the Uninsured. "Dental Coverage and Care for Low-Income Children: The Role of Medicaid and SCHIP". (July 2008)

[2] American Academy of Pediatrics. "Policy Statement: Oral Health Risk Assessment Timing and Establishment of the Dental Home". Pediatrics Volume 111, Number 5 (May 2003).

[3] Grantmakers in Health. "Critical Services for Our Children: Integrating Mental and Oral Health into Primary Care" Issue Brief No. 30 (February 2008)

[4] New York State Department of Health. "Oral Health Plan for New York State" (January 1, 2007)

Best Practices in Children's Oral Health Care

The National Center for Education in Maternal and Child Health at Georgetown University[5], has developed a framework that offers guidance for optimal oral health care for children in the first 10 years of life. As shown in Table One, this framework organizes children into three cohorts, Infancy, Early Childhood and Middle Childhood.

Group	Age	Professional Services
Infancy	0-11 Months	First oral exam within 6 months of eruption of the first primary tooth, and no later than age 12 months, establishing a dental home.
Early Childhood	1-4 Years of Age	An oral examination at year 1 by a dental provider, if not done in infancy and establishment of a dental home. Administration of fluoride supplements as prescribed by a physician or dentist, based on risk and known level of fluoride in the child's drinking water. Discussion of application of topical fluoride and/or sealants with a dental health professional.
Middle Childhood	5-10 Years of Age	Periodic oral examinations and administration of fluoride supplements as prescribed by a physician or dentist, based on risk and known level of fluoride in the child's drinking water. Discussion of application of topical fluoride and/or sealants with a dental health professional. Discussion of the potential need for orthodontia evaluation.

[5] www.brightfutures.org

According to the American Academy of Pediatrics (AAP) periodicity schedule[6], children should receive annual oral health visits at ages three, four, five and six and biannual visits at ages eight and ten. The HEDIS guidelines published by the National Quality Measures Clearinghouse looks at Medicaid members use of dental services. The HEDIS measure is the percentage of members aged 2 through 21 who had at least one dental visit during the measurement year[7].

In summary, the published guidelines and standards call for an early initial dental examination (between the age of 1 and 3) and subsequent follow-up with regular visits and the use of fluoride as a preventive measure. For the purposes of planning for dental care in this community, children have been grouped into three groupings: (1) birth to 3 years of age; (2) 3 to 5 years of age; and (3) 5 to 8 years of age.

Barriers to Optimal Care

Achieving the recommendations described above requires access to a health care provider in infancy and an oral health care provider at the age of one and regularly thereafter when an examination by a qualified oral health provider is recommended[8]. Optimally, oral health should be combined with routine primary care but the structure of the oral health care system differs substantially from medical care from organizational and financing perspectives[9]. One barrier to care is poor coordination between the medical and oral health care systems. The recommendations clearly point to the need to establish a "dental home", a place of regular oral health care.

Another barrier to access care is the absolute supply of oral health providers. While it appears that Onondaga County has a sufficient supply of dentists overall (1 dentist for every 1,352 persons), these office based practices are congregated outside Central Syracuse. Central Syracuse has 1 dentist for every 7,987 people[10]. An area is considered a dental shortage area if there are fewer than one dentist for 4,000 persons[11].

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[6] American Academy of Pediatrics. "Policy Statement on Recommendations for Preventive Pediatric Health Care" Pediatrics Volume 105, Number 3 (March 2000).
[7] National Committee for Quality Assurance (NCQA). HEDIS 2008: Healthcare Effectiveness Data and Information Set. Volume 2, Technical Specifications. Washington DC: National Committee for Quality assurance. July 2007.
[8] Consistent with the EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) in New York State.
[9] GrantMakers in Health "Critical Services for Our Children: Integrating Mental and Oral Health into Primary Care. Issue Brief Number 30, February 2008.
[10] http://www.cnyhsa.com/shortage_areas.php
[11] Health professional shortage area dental designation criteria. relevant excerpts from code 42 of Federal Regulations (CFR). Chapter 1, Part 5, Appendix B (October 1, 1993, pp.34-48). Criteria for designation of areas having shortages of dental professionals. U.S. Department of Health and Human Services; Health Resources and Services Administration (HRSA).

Shortages of dental hygienists are also reported and are likely to become more acute as the only local program training dental hygienists (formerly at Onondaga Community College) closed recently.

Another significant barrier to access is financial; fewer than half as many (26.5%) people with incomes under 100% of the federal poverty level saw a dentist in 2005 compared to individuals with incomes over 400% of the federal poverty level (FPL) (55.6%)[12]. Almost half of low-income persons (individuals with income less than 200 percent of the FPL) do not have dental insurance, compared to a quarter of those individuals over 400% of the FPL. The relationship between income, dental coverage and utilization is clear.

However, dental coverage is not always a guarantee of access. Nationally, even children enrolled in Medicaid with dental coverage were reported to have low rates of preventive dental health care utilization[13]. For children in poverty, the dental coverage is often public health insurance (fee for service Medicaid, managed Medicaid or Child Health Plus). In New York, even though the rates of payment for dental services under Medicaid were increased substantially in 2000 (resulting in more than doubling the number of enrolled children receiving an annual dental visit[14]), the bureaucratic paperwork process for approvals and for routine billing discourage dentists from participating, creating access barriers.

Furthermore, it is commonly reported that dentists are reluctant to treat low-income patients. Frequently, the reasons cited relate to the paperwork burden of billing the public health insurance programs, lower rates of payment under Medicaid managed care plans and the propensity of low-income patients to have higher 'no-show' rates.

Finally, a very commonly cited barrier to access for the low-income populations (individuals covered by Medicaid and Medicaid managed care) is lack of transportation[15]. The tendency for dental practices to be congregated in higher income areas, as noted in the case of Onondaga County cited earlier, compounds the transportation issues.

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[12] Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality (AHRQ): Medical Expenditure Panel Survey (MEPS), "Table 3: Dental Services-Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2005.

[13] Department of Health and Human Services. "Oral Health in America: A Report of the Surgeon General" National Institute of Dental and Craniofacial Research, National Institute of Health. Available at www.surgeongeneral.gov/library/oralhealth/.

[14] American Dental Association. "State Initiatives to Improve Access to Oral Health Care for Children: A Compendium" January 2008.

[15] New York State Department of Managed Care. "Dental Care Survey: Medicaid Managed Care Members" IPRO, February 2007.

The Financing System

The health care financing system for medical care in the United States is a patchwork of programs with varying levels of coverage and complex eligibility criteria. The system of coverage for oral health care is even more complex. Appendix One includes a table that summarizes the varying ways dental health care is paid for in New York State. As can be seen in the table, payment systems vary across two dimensions: the source of payment (e.g. Medicaid, Child Health Plus, private insurance, etc.) and the locus of care (clinic, hospital outpatient department, private practice, etc.). Appendix Two includes a table that summarizes the level of coverage for each of the payers and programs providing services.

The most variation in payment methodologies relate to the Medicaid program. In that program, payment can vary from a fee-for-service fee schedule payment for a private dentist to an all inclusive cost-based threshold visit rates for a federally qualified health center (FQHC). The provisions, if any, for free care also vary. Only Article 28 licensed providers, including the FQHC, the New York State designated school based health centers (SBHC), diagnostic and treatment centers and hospital outpatient departments are required to have a sliding fee scale.

While there is some consistency within the fee-for-service Medicaid program, managed care plans (both publicly and privately funded) vary in terms of coverage and administrative processes.

The rates paid to dental providers by Medicaid managed care plans and Child Health Plus are reportedly lower than the rates paid by fee-for-service Medicaid, which pays rates at the lower end of the range of usual and customary dental charges in New York State. There is significant concern that these low rates of payment impose access barriers. There is also concern that when the Child Health Plus eligibility levels increase to 400% of the federal poverty level, the capacity of the system will be inadequate to ensure access, particularly in light of the low rates paid under this program.

The Syracuse Community

Issues of concern in the Syracuse community relate to the size and location of the target population and the capacity of the delivery system to serve these individuals.

The Target Population

The target population includes all children living in poverty in Onondaga County between the ages of 0 and 10. This population can be viewed in two sub-groups to reflect the existence of programs that serve the population beginning at age three; before that time, there are no formal services beyond the traditional medical care system that offer points of access to oral health care.

Pre-School

The Early Head Start (EHS) and Head Start (HS) programs provide comprehensive developmental services for low-income preschool children between the ages 0 and five years of age and support services for their families. Head Start refers to programs geared for children 3-5 years of age. Early Head Start refers to programs geared for children 0-3 years of age. The programs provide comprehensive developmental services for low-income preschool children and support services for their families. A study done in 2005 shows that the Head Start program has improved access to dental care for this population significantly[16]. In 2007, the Office of Head Start (OHS) and the American Academy of Pediatric Dentistry (AAPD) announced a partnership to develop a network of dentists to link Head Start children with dental homes[17]. However, the Head Start program must rely on the forms of financing in place for low-income persons (Medicaid, Medicaid managed care and Child Health Plus) and is limited in its ability to ensure access because of the limitations of these financing systems, discussed earlier.

School Age

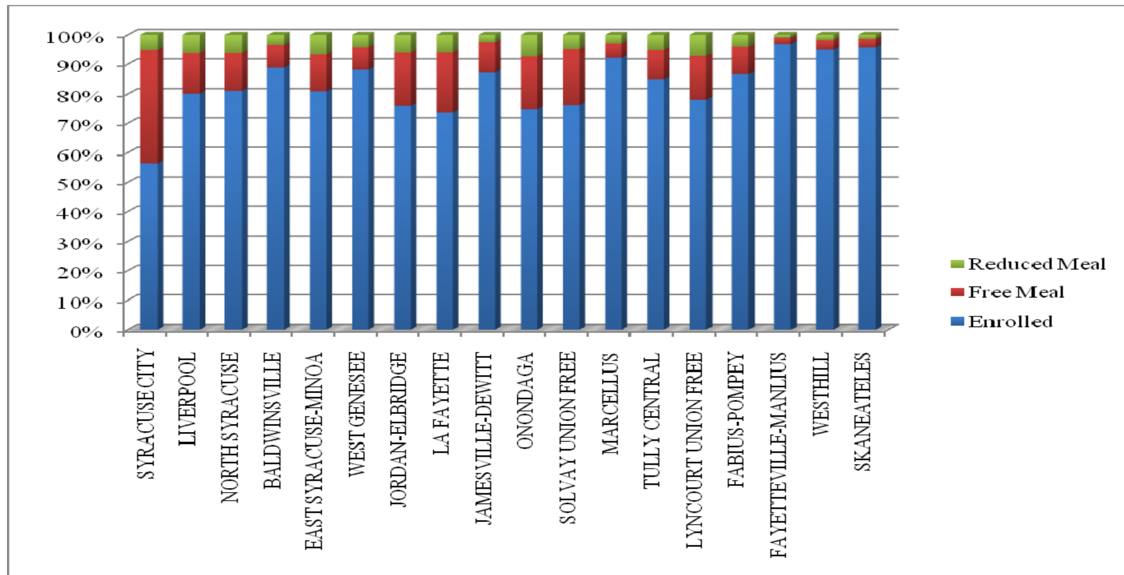
Another subset of the target population is the children who are enrolled in elementary schools between the ages of 5 and 10, consistent with the Middle Childhood population defined by The National Center for Education in Maternal and Child Health. This population is of particular interest because the school setting is an opportunity to reach children who have not accessed dental care due to either financial, geographic or other barriers to care. This program, particularly when a school based health center is linked with a federally qualified health center, has access to higher payment levels under Medicaid fee-for-service and Medicaid managed care.

There are approximately 34,600 children enrolled in elementary schools in Onondaga County. Using the percentages of children participating in free or reduced lunch programs (NSLP Proxy[18]) by school district as a measure, 13,300 (or 38%) live in poverty in 2007. The distribution of children in poverty in Onondaga County, by school district, according to this proxy is displayed below.

[16] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, Administration on Children, Youth and Families. "Head Start Research: Head Start Impact Study, First Year Findings" (June, 2005)

[17] The Head Start Dental Home Initiative

[18] NSLP Free or Reduced Lunch poverty proxy: 130% FPL: Free meals and 185% FPL: Reduced-price meals



In the City of Syracuse, 75% of the children are NSLP recipients, representing over two-thirds of the children in poverty in Onondaga County. Access for these children, particularly those who do not have public health insurance (Medicaid and Child Health Plus), is compromised by the fewer number of local dentists and other dental health professionals, as is discussed in an earlier section of this report.

School based health centers, discussed both in the context of the delivery system and the financing system for oral health care later in this report, offer an opportunity for children in poverty (in the Middle Childhood Cohort) to access dental health care.

The Delivery System

The Syracuse community, like most others in the United States, relies on an oral health care system that is largely composed of private, independent practitioners who provide care in their own offices. As was noted earlier, the availability of private dentists in the City of Syracuse, where the majority of the children in poverty in Onondaga County reside is limited. While there are a number of providers that serve relatively small numbers of children in poverty (including some private practices (including the Small Smiles Dental Center)) and the McAuliffe Center sponsored by Loretto, four primary sources of dental care in Syracuse serving the majority of this population. These programs are summarized in the table below.

Program	Licensure	Location
Syracuse Community Health Center (SCHC)	Diagnostic and Treatment Center (Federally Qualified Health Center)	South Salina Street Syracuse, New York
City of Syracuse School Based Health Centers (SBHC)	School Based Health Centers operated by Syracuse Community Health Center (FQHCs)	Bellevue Elementary Delaware Elementary Dr. King Magnet Elementary Dr. Weeks Elementary
Upstate Medical University (UMU Dental Clinic)	Hospital Outpatient Department	South Adams Street Syracuse, New York
St. Joseph's Hospital Health Center (SJHHC Dental Clinic)	Hospital Outpatient Department	Prospect Street Syracuse, New York

The program model that is position most favorably to reach children in poverty in Onondaga County appears to be the school based health center (SBHC) that is designated as a federally qualified health center (FQHC) because the payment system under Medicaid and Medicaid managed care provide for a cost-related rate of payment, higher than the rates paid to other providers because under both programs it receives a cost-based rate. The SBHC model also carries with it a requirement to provide screening, education and referral for all children at no cost and a sliding fee scale based on family income.

Local Implementation/Organizational Options

The most desirable outcome would be a dental home for children in poverty in Onondaga County that facilitated compliance with the best practices in oral health, similar to the recommendations described in an earlier section of this report. This would require integration of oral health with primary medical care, a financing mechanism (largely through public health insurances that pays providers at acceptable levels) and an adequate supply of dental health professionals accessible to communities where children in poverty reside who are willing to accept and care for low-income individuals. Achieving this goal requires a multi-faceted approach, addressing payment issues, workforce development and community education.

An alternative or intermediate approach to reaching children in poverty would be to build on existing systems. Where a child does not have a private dental provider, the Early Head Start and Head Start programs offer opportunities to reach children between the ages of 0 and five but reforms in the public insurance payment systems may be necessary for this vehicle to be as effective as it might be to ensure access once pathology is identified. An expansion of the school based health centers already in place can reach children between five and ten years of age. This model is displayed in the table below.

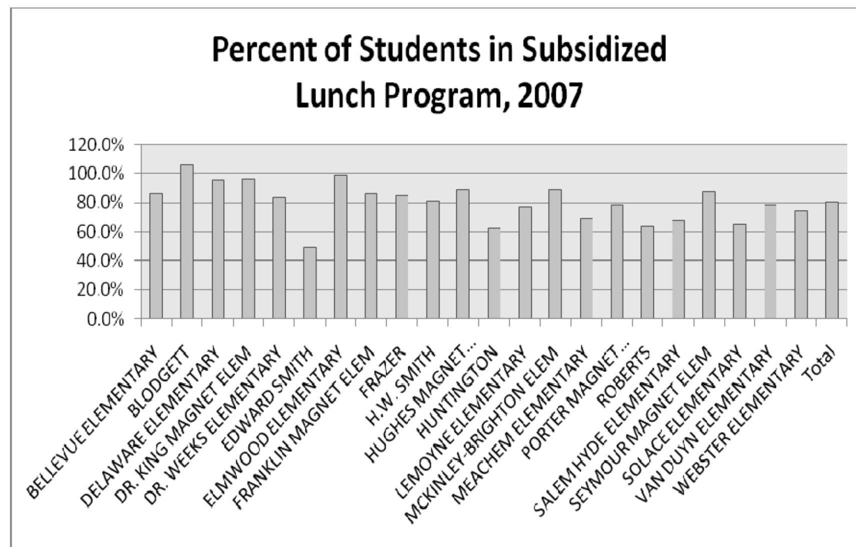
Syracuse Dental Delivery System Model

Age Group	Point(s) of Entry	Negative Exam	Requires Referral
0-3 Years of Age	Primary Care Provider Early Head Start	No Action	Private Dental Provider SCHC SJHHC Dental Clinic UMU Dental Clinic
3-5 Years of Age	Primary Care Provider Head Start	No Action	Private Dental Provider SCHC School Based HC* SJHHC Dental Clinic UMU Dental Clinic
5-8 Years of Age	Private Dental Provider School Based HC	No Action	Private Dental Provider SCHC School Based HC SJHHC Dental Clinic UMU Dental Clinic

*Where a Pre-Kindergarten program is in place.

School Based Health Centers

Using the percentage of children receiving reduced price or free lunch as a measure, the degree of penetration of the school based clinics can be determined. The existing four school based health centers reach 354 elementary school students, over 86% of whom participate in the reduced price or free lunch program. The graph below offers one perspective on prioritization of elementary schools in the City of Syracuse to achieve maximum penetration of that population.



The Syracuse Community Health Center, in collaboration with the Syracuse City Schools, has announced a program where the school based health center programs would be expanded to include seven additional elementary schools (Blodgett, Elmwood, Franklin, Frazer, H.S. Smith, McKinley-Brighton, and Seymour). This would expand the program to reach 911 children (57% of the total elementary population in Syracuse City Schools), nearly 80% of whom receive reduced or free lunch. Overall, this expansion would reach slightly over 60% of children in poverty in the City of Syracuse. However, only Seymour operates a pre-K program at this time, which does not extend the school based health center access to a substantial number of children under the age of 5.

Action Areas

Action areas have been defined and are presented in the framework of primary care, prevention and policy.

Primary Care

- A key part of primary care, particularly for the very young children, is access to dental care through their medical care provider. Integration of oral health into traditional medical care is important. However, the model for this integration needs further exploration and discussion. Options range from more health education and early referral by primary care providers to a more active role in oral health examinations by primary care practitioners.

  However, in order for dental issues to be well integrated into routine medical practice, education in provision of dental services must be incorporated into medical school curriculums and into continuing medical education.

- Capacity issues also require further examination. There are shortages of dentists and dental hygienists, particularly in certain parts of Onondaga County. This shortage will become more acute when CHP eligibility guidelines increase to 400% of the federal poverty level on September 1, 2008 and more children are eligible for dental coverage.

Prevention

- The cornerstone of prevention is health education. Programs of health education that emphasize good oral health habits and also encourage families to enter into dental care early are essential.
- Flouride is an important preventive strategy. Flouridation of public drinking water as well as identification of areas where supplements are necessary is critical.

Policy

- Form follows financing. The payment policies that structure public health insurance's dental coverage play a large role in access for children in poverty. A number of policy recommendations have been identified in this area, including:

    - While fee for service Medicaid rates are currently at the lower end of the range found for dental services paid by other payers, they do not pose an insurmountable barrier to access. However, in order to ensure that they do not, they must be regularly updated, the administrative processes associated with billing and receipt of prior approvals must be streamlined and the ADA billing forms integrated to the process to minimize the administrative cost to the private dental providers.

    - The Medicaid program has to take steps to ensure that the Medicaid managed care plans and Child Health Plus pay rates to providers that are at least consistent with the fee-for-service Medicaid rates. HEDIS measures of dental service utilization might be used as a pay for performance incentive to ensure that rates of payment are adequate.

    - Medicaid should pay for dental services provided by licensed dental hygienists that are part of an overall plan of dental care supervised by a licensed dentist (consistent with EPSDT guidelines under the Medicaid program) but not requiring the physical presence of a dentist during each service.

- Children entering school are required to have a certification from their primary care provider that they have had certain immunizations. Using this model, a proposal has been floated to require (or just recommend) that a similar certification be provided by parents on enrollment in school to encourage early oral health examinations. A related issue is whether a dental hygienist could complete the certification or whether it requires the supervision (or direct examination) by a licensed dentist.

- Somewhat related to the Medicaid recommendations and the dental certification discussed above is scope of dental practice for hygienists. Consideration should be given to expansion of the scope of practice for hygienists, the potential of licensure for independent practice and independent billing.

- If oral health is to be integrated into primary care, the payment systems for primary care need to be considered. In this context, the current initiative to move away from the threshold visit rate for many Article 28 licensed primary care facilities to an ambulatory payment group (APG) should incorporate a discussion of the role of these primary care providers in oral health.

Appendix One – Current Payment Structure for Dental Services in New York State

Organizational Model	Traditional Model	Medicaid Managed Care **	Child Health Plus	Healthy Families	Private Insurance Third Party Payer	Self-Pay
Article 28 Federally Qualified Health Center (FQHC)	Threshold rates set prospectively based on historical costs trended forward which vary between organizations	Fee-for-service rates which varies between MCOs supplemented by a prospectively set cost-based threshold visit rate.	Fee-for-service which varies between MCOs.	Fee-for-service rates which varies between insurers.	Fee-for-service rates which varies between insurers.	Fee-for-service, which vary between insurers. Sliding fee based on patient's household income required.
Article 28 Diagnostic and Treatment Center (Non-FQHC)	Threshold rates set prospectively based on historical costs trended forward and held to ceilings which vary between organizations.	Fee-for-service rates which varies between MCOs with no state supplement.	Fee-for-service rates which varies between MCOs.	Fee-for-service rates which varies between insurers.	Fee-for-service rates which varies between insurers.	Fee-for-service, which vary between insurers. Sliding fee based on patient's household income required.
School-Based Health Center	Threshold rates set prospectively based on historical costs trended forward and held to ceilings which vary between organizations.	Services can be billed under the regulations applicable to SBHCs under traditional Medicaid.	Fee-for-service rates which varies between MCOs.	Fee-for-service rates which between insurers.	Fee-for-service rates which varies between insurers. Sliding fee scale based on patient's household income is required.	Fee-for-service rates which vary between insurers/ Sliding fee scale based on patient's household income is required.
Hospital Outpatient Department	Threshold rates set prospectively based on historical costs trended forward and held to ceilings which vary between organizations.	Fee-for-service rates which varies between MCOs with no state supplement.	Fee-for-service rates which varies between MCOs.	Fee-for-service rates which varies between insurers.	Fee-for-service rates which varies between insurers.	Fee-for-service rates, which vary between insurers. No sliding fee scale is required.
Private Practice	State set fee-for-service rates. All private practitioners receive same rates.	Fee-for-service rates which varies between MCOs.	Fee-for-service rates which varies between MCOs.	Fee-for-service which varies between insurers.	Fee-for-service rates which varies between insurers.	Fee-for-service rates, which vary between insurers. No sliding-fee scale is required.

Notes: * Certain of the provider groups will move from threshold visit rates to a case payment system (Ambulatory Payment Groups) phased in over four years beginning in December 2008. ** Dental care may be provided either as part of the managed care service or on a fee-for-service basis. MCOs that provide dental care services may establish their own panel of dental providers or they may sub-contract with a dental benefits provider.
July 10, 2008

Appendix Two – Coverage Levels for Dental Services in New York State, by Payor and Program

Organizational Model	Traditional Model	Medicaid Managed Care **	Child Health Plus **	Healthy Families **	Private Insurance/Third Party Payer **	Self-Pay
Article 28 Federally Qualified Center (A28 FQHC)	10 Visits per year in combination with other provider visits. Presumptive eligibility for Medicaid coverage for 45 days.	10 visits per year in combination with other provider visits.	Varies by plan and by county.	Varies by plan.	Varies by plan and by county.	Sliding Fee Scale
Article 28 Diagnostic and Treatment Center (Non-FQHC)	3 visits per year.	Varies by plan and by county	Varies by plan and by county	Varies by plan	Varies by plan and by county	Sliding Fee Scale
School-Based Health Center (SBHC; SBHC-D)	10 visits per year in combination with other provider visits. Dental prophylaxis must be provided at no cost to child. ***	SBHC & SBHC-D are covered by an MA Waiver & bill the A28 D&TC rate	Varies by plan & by county. Dental prophylaxis must be provided at no cost to child. ***	Varies by plan. Dental Prophylaxis must be provided at no cost to child. ***	Varies by plan & by county. Dental Prophylaxis must be provided at no cost to child. ***	Dental Prophylaxis must be provided at no cost to child. ***
Hospital Outpatient Department	3 Visits per year	Varies by plan & by county	Varies by plan & by county	Varies by plan	Varies by plan & by county	Sliding Fee Scale
Private Practice	3 visits per year	Varies by plan & by county	Varies by plan & by county	Varies by plan	Varies by plan & by county	None; Voluntary-Sliding Fee or Payment schedule

Notes: *Prior approvals required for selected procedures. ** Prior approval process varies by plan. *** Dental Prophylaxis includes: Dental Health Education, Screening, Fluoride Application, Sealants, as appropriate and Referrals for Necessary Treatment.

July 30, 2008.