

Treating Pain Is Not Enough: Why States' Emergency-Only Dental Benefits Fall Short

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Thirty-eight million adults with low incomes rely on the Medicaid program for their health care, and their states' Medicaid benefits are a crucial factor in their access to oral health care.¹ While Medicaid covers a fairly comprehensive set of services to address most health needs, the scope of dental benefits that Medicaid provides to adults varies from state to state. States that provide emergency-only dental coverage omit care that is important to health and well-being.

Unlike pediatric dental benefits, which must be covered in every state Medicaid program under federal law, dental care for adults is an "optional" benefit under the law: if states elect to cover adult dental care through their Medicaid programs, the federal government will match states' investment. However, states have great latitude to determine the scope of covered adult dental services, and some offer none at all.

Researchers use the following four categories to describe the extent of states' dental benefits for adults: none (in 3 states); emergency-only (in 14 states); limited* (in 17 states); and extensive (in 17 states).² When state budgets are tight, states often cut back their adult dental coverage to very limited or emergency-only coverage.

This variation in dental coverage matters. Oral health and overall health are linked: when the body is healthy, the mouth is more likely to be healthy; and conversely, disease in the mouth can spread to other parts of the body.³ People facing barriers to oral health, such as their state cutting back their dental coverage or offering none at all, ultimately face barriers to their overall health and well-being. To better understand the consequences of insufficient dental coverage, Families USA investigated the limitations of emergency-only coverage.

Families USA conducted a survey of the 14 states that cover emergency-only dental services: Arizona, Florida, Georgia, Hawaii, Idaho, Maine, Maryland, Mississippi, Nevada, New Hampshire, Oklahoma, Texas, Utah, and West Virginia. We received responses from state dental directors and/or oral health coalitions in 10 of these states.

*Medicaid pays for oral health care beyond emergencies, but still covers a limited number of procedures up to an annual expenditure cap of \$1,000 per person or less.

What can we learn from states with “emergency-only” dental coverage?

In most states that limit coverage to oral health “emergencies”—generally, situations where a person is in severe pain or has an acute oral infection—Medicaid-covered care often consists of extracting an infected tooth, but not filling or restoring a tooth. Some states face challenges making even this minimal care accessible. Through this survey, we sought to learn more about: how emergency-only coverage varies in each state, how widely the benefits are used, where the care is provided, what oral health coalitions and dental directors see as unmet needs (especially for people who have other medical problems that are worsened by their oral health conditions), and what work is underway to improve the coverage through either Medicaid’s managed care or fee-for-service system.

Key findings include:

- » Emergency-only states all cover limited services to address severe pain, generally including extractions. A few states provide dentures up to a dollar limit, but most emergency-only states do not provide restorative care (such as root canal treatment or filling a cavity), nor cleanings that would address underlying disease.
- » In some states, Medicaid managed care plans provide plan-specific extra offerings for adults as “value added” benefits.
- » Finding appropriate providers for emergency-only dental services can be difficult. State Medicaid programs end up paying for expensive hospital emergency department visits when appropriate dental services are not available.
- » More comprehensive benefits and fewer prior authorization requirements would encourage provider participation.

» Low-income seniors and people with disabilities who rely on Medicaid and Medicare for health coverage are among those affected by the lack of dental coverage. While some Medicare beneficiaries would be helped by more extensive Medicaid benefits, a comprehensive Medicare dental benefit is also needed to meet this population’s needs.

Which states responded to the survey?

Arizona, Georgia, Hawaii, Idaho, Maine, Maryland, Nevada, New Hampshire, Texas, and West Virginia are included in this analysis. Idaho is in the process of expanding its benefits, but provided mainly emergency coverage in its “basic” benefit for adults at the time of our survey.

Florida was in the process of rebidding Medicaid managed care contracts, and could not be interviewed while that effort was underway. We were unable to speak with representatives in Oklahoma, Utah, and Mississippi.

Ultimately, this survey reinforces the fact that emergency-only dental coverage is better than nothing, but that states should invest in comprehensive Medicaid dental coverage for adults if they want to effectively keep their populations healthier and reduce other health care costs.

How did the responding emergency-only coverage states' dental benefits differ?

These 10 states all covered some care to alleviate acute pain and infections—predominantly a limited exam to identify the source of the problem, extraction of teeth, and drainage of abscesses. Antibiotics were covered either as a dental or medical benefit. Medicaid coverage of restorative care, however, was rare in these states. Without preventive care and without treatment of gum disease and tooth decay, emergencies can and do recur.

Some states provide more dental care to certain adult populations, such as pregnant women and people residing in long-term care facilities or receiving care through home- and community-based services programs.

West Virginia limited emergency extractions to two per year, a limit not found in other states.

While the following table is not conclusive, since we did not review provider billing manuals and other program documents, it does identify some differences in benefits that emerged:

State	Key emergency benefits in addition to problem-focused exam, extraction, drainage of abscesses	Types of adult Medicaid enrollees who can receive more than emergency dental care
Arizona	Services including crowns, caps, re-cementation up to \$1,000	Long-term care facility residents; home- and community-based services waiver participants; and Tribes (up to an additional \$1,000 cap). Limited exceptions for transplant and cancer cases.
Georgia		Pregnant women, with referral from OB/GYN
Hawaii	Dental services are limited to emergency treatment which does not include services aimed at restoring and replacing teeth. Includes only services for the following: Relief of pain; elimination of infection; and treatment of acute injuries to teeth and supporting structures of the oro-facial complex	Transplant patients; individuals with developmental disabilities

State	Key emergency benefits in addition to problem-focused exam, extraction, drainage of abscesses	Types of adult Medicaid enrollees who can receive more than emergency dental care
Idaho <i>Note: At the time of our survey, Idaho had an emergency-only benefit which has since expended.</i>	<p>Prior to July 2018: Can move into an enhanced benefit category if there are special health needs.</p> <p><i>As of July 1, 2018, all Medicaid-eligible adults will receive enhanced dental benefits regardless of which Medicaid plan they are on.</i></p>	<p>People with special health care needs (this can include people with referrals from dentists for acute periodontal disease, broken teeth, or need for dentures)</p> <p><i>As of July 1, 2018, all Medicaid-eligible adults will receive enhanced dental benefits regardless of which Medicaid plan they are on.</i></p>
Maine	Services to prevent imminent tooth loss or correct an underlying medical condition	People with certain qualifying medical conditions are eligible for dentures; residents of intermediate care facilities for individuals with intellectual disabilities
Maryland	Maryland recently enacted legislation to establish a pilot Medicaid adult dental program that will provide more benefits (Chapter 621, 2018).	People with rare health conditions or expensive diagnoses through the “Rare and Expensive Case Management” program; pregnant women
Nevada	Dentures; restoration of abutting teeth to hold a partial; treatment to avoid life-threatening health complications ⁴	Long-term care facility residents; pregnant women
New Hampshire	Treatment of severe trauma in an emergency	
Texas	Unless a managed care plan has opted to cover more, care is required only if the dental diagnosis is causally related to a life-threatening medical condition, has been specifically authorized, or would be payable under Medicare. (Texas Rule 354.1149)	Long-term care residents; home- and community-based services waiver recipients

State	Key emergency benefits in addition to problem-focused exam, extraction, drainage of abscesses	Types of adult Medicaid enrollees who can receive more than emergency dental care
West Virginia	Biopsy and removal of tumors	None through Medicaid, but the Temporary Assistance for Needy Families (TANF) program can pay for some restorative work to support adults' employability

In some emergency-only coverage states, managed care plans provide adults with various extra offerings

Some states invite or encourage managed care plans to provide what are known as “value-added” services beyond the standard benefits to adults in order to improve the overall health of plan enrollees. Plans have discretion over the specific value-added services they will offer and what amount they will pay for, and whether they will offer them at all. The plans provide these services at no additional cost to the state; the services are not considered in the rate-setting process, which sets plans’ payments based on the cost and likely use of services that are part of the Medicaid state plan. Instead, plans offer these benefits out of their overhead or profits, and assume financial risk for these benefits because they determine that there are other advantages to doing so:

- » Plans may determine that providing value-added benefits will prevent other costly health problems.⁵
- » Providing value-added benefits may make plans more competitive in a state’s procurement process.
- » These benefits also attract members, and states list them in plan comparison charts that Medicaid enrollees can view when they are choosing their health plan.

Value-added benefits have provided a “baby step” toward improving dental benefits in a few states, and additional states may be considering this approach in the near future:

- » In Texas, some managed care plans do not elect to provide adult dental coverage among their value-added services, while others provide services ranging from a dental kit, to low-cost dental services for adults, to annual dental benefits of anywhere between \$250 and \$500 of dental checkups, cleanings, and X-rays, either for pregnant members or for all adults.
- » In Maryland, all managed care organizations (MCOs) cover an oral exam and cleaning twice a year for adults; and six out of the nine MCOs provide fillings. (Some list benefit maximums and/or cost sharing.)⁶

Some managed care plans include additional benefits for a subset of adult members needing certain oral health procedures that are shown to improve other health outcomes:

- » In West Virginia, managed care plans cover some additional cleanings, exams, and X-rays for pregnant women. For instance, one plan notes in its member handbook that it covers two preventive oral health visits for pregnant women.⁷ This is not a prominently advertised

benefit, but it is in the interest of the plan, the state, and the members: oral health care during pregnancy improves the oral health of the woman, prevents complications of dental disease during pregnancy, can decrease early childhood caries, and may reduce preterm and low-birth-weight deliveries.⁸

- » In Nevada, the dental plan provides additional dental cleaning visits for pregnant women, beyond what the state reimburses, and also provides periodic oral evaluations and cleaning for other adults.⁹

Some state officials noted that this approach is not practical everywhere. In some states and counties, Medicaid is not provided through managed care. In some other counties, where there is little competition among managed care plans or where most enrollees are auto-assigned to plans, MCOs have little incentive to increase their benefits to be more attractive to enrollees. They may, however, determine that it is cost-effective to offer more dental benefits, at least to some populations, since oral disease effects overall health, and a state can encourage this in its request for proposals. One state noted that the costs of additional benefits to effectively address its enrollees' enormous unmet needs could not actually be absorbed by plans without additional funding, and the state would need to increase its Medicaid budget in order to offer responsive benefits. The limited nature of value-added benefits is reflected in the state examples we found.

There are definite advantages to adding more comprehensive adult dental benefits to a state's Medicaid program instead of leaving add-ons to managed care plans' discretion. For one, defining the benefits at the state level ensures uniformity and can result in a more stable benefit structure. More broadly, plans cannot sustain a comprehensive

benefit unless funding for it is carefully built into plans' rates. Even if adding a more comprehensive benefit increases overall Medicaid costs, states will be able to claim federal matching funds that offset much of the increased costs for these services.

Finding appropriate care providers for emergency-only dental services can be difficult. State Medicaid programs end up paying for expensive hospital emergency department visits when appropriate dental services are not available.

A recent study of hospital emergency department (ED) visits by adults for chronic dental conditions in Maryland found that in 2016 alone, more than 22,000 adults covered by Medicaid visited hospital EDs for their dental conditions. Medicaid paid nearly \$10 million for those ED visits, in addition to \$1.4 million for adults who required hospitalization for their dental needs. Hospital EDs are usually not equipped to provide appropriate treatment for chronic dental conditions. Moreover, they are costly, the study noted; since people usually only get palliative care in the ED (that is, treatment of pain but not its underlying cause), they often return with another episode of severe dental pain. In fact, 25% of the adults who were treated in hospital EDs returned within a year with a similar dental complaint.¹⁰

Oral health advocates and officials in other states echo this concern. Representatives from the Maine Oral Health Coalition (MOHC) noted that EDs may provide prescriptions for antibiotics to treat an infection and/or pain medication, and instruct the person to see a dentist to get the tooth treated—but without a specific referral to a dental provider who accepts Medicaid, patients may not find care. Moreover, dentists who accept adult Medicaid benefits are in short supply.

When Medicaid does not cover an oral health care need, there are few other resources for low-income adults to get that need met.

Outreach to dental providers could improve their participation in Medicaid, the MOHC believes. A survey of Maine dentists a few years ago found that a majority did not know what Medicaid covered or how to get reimbursed, and more might accept Medicaid if they received additional information. The Coalition suggested legislation requiring such education and annual outreach to dental providers.¹¹ This was included in a proposal introduced in the legislative session in 2017 and carried over into 2018.

Nevada is taking concrete steps to improve ED referrals to dentists who participate in Medicaid. It has contracted with a new statewide dental plan, which will be responsible for this coordination. Meanwhile, Nevada EDs vary in their ability to handle dental cases. One has improved services by using dental residents on rotation.

Respondents from some states reported that multiple managed care and/or dental plans added complexity to referral systems. The ED, dentist, or patient had to determine which plan the patient was in, which providers to use, and how to get authorization under that plan for basic or value-added services.

A fuller benefit and less prior authorization would encourage provider participation

Respondents from several states reported that the extremely limited services for which providers could claim reimbursement discouraged dental providers for adults from participating in Medicaid. In some states, burdensome prior authorization requirements also discourage providers. Mostly, respondents said, the only providers who would agree to see adults are those who already serve children and federally qualified health centers (FQHCs). However, those providers and their resources are already stretched thin.

For example, the New Hampshire Oral Health Coalition conducted a baseline survey of community-based oral health programs in 2015-2016. For adults, service models included oral health and dental programs in a variety of settings including senior centers, mobile/van programs, free-standing and FQHC operatories, nursing homes, and hospitals. There are also a few voucher programs that pay for limited services within a cap. These providers offered limited services, and two-thirds of responding programs reported that it was difficult to find a dentist to provide urgent care.¹²

There are few alternative oral health care resources for adults

When Medicaid does not cover an oral health care need, there are few other resources for low-income adults to get that need met. Though some FQHCs provide dental care on a sliding fee scale, the resources they use to pay for the multiple needs of uninsured and underinsured patients are stretched very thin—especially in states that have not expanded Medicaid. As a consequence, the fee scales some states set for dental care are still too high for many low-income adults, and there may be waiting lists for care.

Some state dental directors compile lists of community resources for dental care. These show that neither discounted nor sliding-fee-scale care is available in some counties, and that charitable resources including mobile clinics are only periodically available.

Implications for low-income Medicare beneficiaries

Medicare beneficiaries with low incomes and limited assets often qualify for Medicaid in addition to Medicare. The “dually eligible” include seniors and people with total disabilities who meet the Medicaid income standards in a state. Medicare does not currently include an oral health benefit. Nationally, advocacy groups are urging the federal government to allow Medicare to cover medically necessary oral health care for beneficiaries, particularly when a dental condition poses a serious risk to a patient’s health or treatment for an underlying medical condition. Enacting a comprehensive Medicare dental benefit federally would go further to keep seniors healthier and reduce other health care costs.

Some states have documented large unmet needs for oral health care among low-income seniors, and these data point out the need both for care that is related to other medical conditions, and for comprehensive oral health care more broadly. For example, in West Virginia, 34 percent of seniors screened at congregate meal sites had not seen a dentist for five or more years, 77 percent were missing six or more teeth, and 32 percent had untreated tooth decay.¹³ In a survey of Maryland senior centers, nutrition sites, assisted living centers, and nursing homes, rates of untreated decay ranged from 21 percent in senior centers to 40 percent in nursing homes.¹⁴

States’ emergency-only dental care may not provide the oral health services needed by people with serious medical conditions

We asked survey respondents if their states’ Medicaid coverage for oral health emergencies allowed for care in such “medically necessary” circumstances, and what changes they would recommend. While this coverage is better than nothing, we heard about many shortfalls, including:

- » “A patient could not be cleared for knee replacement surgery until gum disease was resolved, and the state’s emergency dental benefit did not cover that; another needed treatment prior to heart surgery. The patients had to rely on a charitable “donated dental” program, and that has a long waiting list.”
- » “The research showing the link between diabetes, Alzheimer’s, heart disease, etc. and periodontal disease grows every day. The fact is that an elderly individual cannot maintain their overall health without access to care. Oral health quickly erodes without regular access to oral health care. Preventive oral health care is critical to the health of the Medicare population.” (This person was noting the needs for people dually eligible for Medicare and Medicaid.)
- » “We can drain an infection and extract, but that is all. Studies show that diabetic patients in particular need regular scaling and cleaning.”
- » “Medicaid in this state is not paying for exams to give people clearance for surgeries. For people with medical needs such as heart, joint, kidney, cancer, hospitals refer to the one dental school in the state for an exam to get the medical clearance, and that school

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ends up providing uncompensated care to ready such patients—the school spends \$6 million on uncompensated care annually, while the hospitals are compensated for their own services. The wait for clearance ties up hospital operations and creates workflow problems. In this state that covers a limited number of extractions per year, six patients are in a hospital right now that need multiple extractions prior to chemotherapy.”

Two states felt that their Medicaid programs could address some underlying conditions through the “medically necessary” exceptions to their emergency-only benefits. Idaho, which has an enhanced benefit for people with special health needs in addition to its basic health benefit, can provide an array of medically necessary care with justification—but its income eligibility guidelines are far below the poverty line, leaving many low-income Medicare beneficiaries without additional coverage. Idaho’s adult dental coverage will improve further this year: as of July 1, 2018, all Medicaid-eligible adults will receive enhanced dental benefits, which are reinstated under Idaho House Bill 465.

Maine covers several categories of oral health service that provide flexibility to assist someone with other medical needs:

C. Extraction of teeth that are severely decayed and pose a serious threat of infection during a major surgical procedure of the cardiovascular system, the skeletal system or during radiation therapy for a malignant tumor.

D. Treatment necessary to relieve pain, eliminate infection or prevent imminent tooth loss.

E. Other dental services, including full and partial dentures, medically necessary to correct or ameliorate an underlying medical condition, if the Department determines that the provision of those services will be cost-effective in comparison to the provision of other covered medical services for the treatment of that condition.¹⁵

However, actually receiving Medicaid reimbursement for these services depends on the competency and persistence of the biller in a dental office. The dental office must obtain prior approval for certain services, as well as determining how to best code them. Further, low reimbursement rates limit access to care.

In the end, emergency care is better than nothing, but Medicaid and Medicare should cover comprehensive dental care for adults to truly address Americans' health needs and reduce avoidable health care costs.

Respondents pointed to many serious unmet needs. In particular, extracting teeth to deal with pain, and not filling or replacing them, eventually leaves people edentulous—that is, without teeth to chew, and with an appearance that impedes their social interactions and ability to get jobs. In some states, people are left without any teeth to which to connect a partial denture. Extraction-focused coverage leads to complete edentulism in a patient. This results in a situation where a complete denture is the only treatment option—and that is only if the patient can afford it.

Likewise, the lack of preventive care is a serious problem. An increasing body of research shows a link between oral health and chronic illnesses such as diabetes.¹⁶ “Even though we have this limited benefit, the key to me is that you are treating the downstream problem, and symptoms rather than the disease. Expanding to include preventive services would provide more cost-efficient care and better outcomes,” said one respondent. Another noted, “It makes no sense to provide comprehensive care up to age 21 and then cut it off—we should at least protect the state’s investment by providing preventive care to adults.”

States have taken creative steps to expand care by enlarging the list of services that can be provided in an emergency situation, allowing managed care plans to provide add-on benefits, and providing pathways for people with special health needs to receive more care. But state oral health coalitions and state dental directors are acutely aware of unmet needs that could best be addressed by adding comprehensive oral health benefits in the Medicaid and Medicare programs.

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