Florida Institute for Health Innovation
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Issue Brief

Improving Access to Oral Health Care for Children and Youth with Special Health Care Needs in Florida

Children and youth with special health care needs (CYSHCN)[1] are defined as "children and youth with at least one chronic physical, developmental, behavioral, or emotional condition who also require health services beyond those generally needed." It is estimated that **797,376 (18.9%) children and youth in Florida (FL) under the age of 18 have a special health care need.**[2]

Dental caries (tooth decay) is the most common chronic childhood disease among children ages 6 to 19; four times more prevalent than asthma among adolescents ages 14-17.[3] Due to the disruption of COVID-19 many are anticipating an increase in children's oral disease in coming years.[4] Dental care continues to be one Florida's greatest unmet needs. CYSHCN, particularly with serious mental illness (MI) and intellectual and developmental disability, are **more likely to have unmet dental needs and experience dental decay, periodontal disease, and tooth loss** compared to their counterparts. Children with physical, developmental, or emotional disabilities may lack the ability to understand, assume responsibility for, cooperate with preventive oral health practices, or verbalize dental pain.[5] Many serious MIs (e.g., bipolar disorder and schizophrenia) begin to emerge in adolescence. Risk factors including poor nutritional status, poor oral hygiene, high intake of sugary drinks, low socioeconomic status, and the use of certain medications are more prevalent in person with MI.[6] CYSHCH with systemic health problems are especially vulnerable to the effects of oral disease.

The ability to obtain dental care for this population can vary **by degree of poverty, insurance status, and the severity and complexity of the condition.**[7] 40.2 % of Florida's CYSHCN live in household at or below 200% FPL[8] and approximately **55% are covered by Medicaid/CHIP.**[2] CYSHCN are at greater risk and require extra help and care to achieve and maintain good oral health. Appropriate and timely dental care for this population is critical to preventing the development of new oral health issues and treating emerging health conditions.

For Immediate Action, the State of Florida:

→ Must utilize a portion of federal public health emergency response funding and Medicaid surplus to address critical reimbursement and provider incentive gaps for CYSHCN.

→ Acknowledge and reward compassionate and innovative pediatric and general dental providers working diligently to overcome restrictive and unnecessary barriers to collaboration and eliminate systemic waste.

→ Close cavernous oral health disparities by funding implementation and evaluation of medical-dental integration and evidence-based oral public health interventions for CYSHCN.

→ Integrate social determinants of health and treatment of patients with special needs into the dental curricula using an interprofessional and person-centered care approach with opportunities for hands-on application.

→ Increase knowledge and equitable treatment of CYSHCN by incentivizing dental professionals to complete a continuing education course on treatment and practice techniques of CYSHCN as part of their hours of continuing professional education required for biannual licensure renewal.

Medicaid-Enrolled CYSHCN: FIHI's Oral Health Parent Advisory Committee

FIHI developed an advocacy group of parents from across the state whose children, up to 18 years old, utilize Medicaid for their dental care. The purpose of the Oral Health Parent Advisory Committee (OH PAC) is to ensure that the true experts have a voice as it relates to their child's oral health care. In FL, Medicaid - enrolled (55%) children, especially children with special health needs, face additional barriers to oral health care access. Due to their increased vulnerability, maintaining good oral health is of a particular concern for this population.

Feedback from the Committee

Few dental offices that serve Medicaid recipients in Florida are equipped to treat and accommodate children with special needs and many simply don't want to treat children with special needs for lack of familiarity and education with this population.

"Dental offices need to be more accommodating and understand that special needs children have quirks and difficulties."

"The dentist didn't feel comfortable examining our disabled son and since then we have been in the process of searching for Medicaid dentist to provide oral health services for him without sedation."

"Special needs children are treated differently…providers are quick to recommend sedation for simple procedures and don't provide dental care without sedation."

"They need to go back to school and have the properly trained."

Medicaid participating dentists are very quick to recommend sedation for simple dental procedures. Often the providers are more concerned about the length of time it takes to treat a child with special health care needs rather than health outcomes. Many parents find sedation to be unnecessary and traumatic and don't have enough time to get a second opinion for fear of losing their appointment and having to wait months to get another appointment.

"It is difficult to find dental providers that accept Medicaid let along feel comfortable providing care to children with special needs"

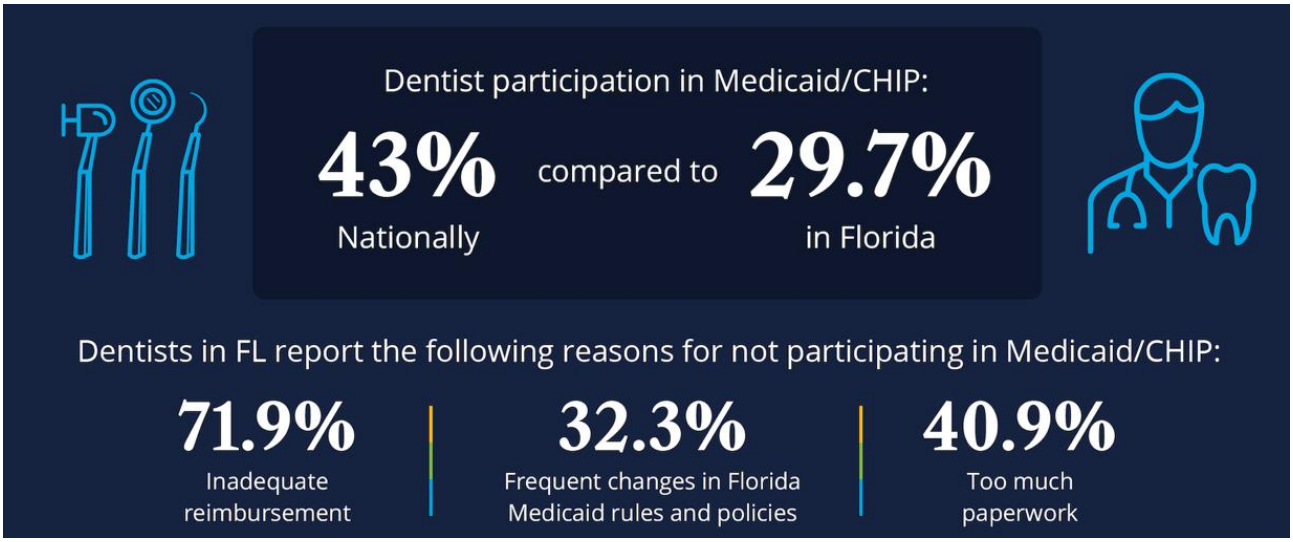
"Some offices only accept Medicaid patients one day a week and you have to rearrange your entire life to get an appointment."

System Barriers

It is recognized that the special health care needs population has unique challenges with varying levels of complexity when seeking dental care. This makes diagnosis and treatment difficult. In addition to these factors, the reluctancy of dentists to treat CYSHCN due to inadequate financing[9] and lack of proper training and thus comfort,[10] are among the most common barriers.

According to 2018-19 National Survey of Children's Health,[8] approximately 23.3% of FL children (ages 1-17) with special health care needs did not have a preventive dental visit in past 12 months compared with 15.5% nationally. While the workforce data from Florida Department of Health shows that 84.4% Florida dentists indicated that they had seen at least one patient having special health care needs in the last 12 months, the vast majority (69.7%) saw no Medicaid patients during 2017-18.[11] This is of great concern because 55% of CYSHCN in FL use Medicaid/CHIP to access dental

care. Only 29.4% of Florida dentists participate in Medicaid/CHIP compared to 43% nationally. Consequently, finding a dental office, especially among Medicaid-enrolled families, and one that can accommodate child's special needs, is difficult.



The key issue for Medicaid in Florida is having enough dental providers, specifically pediatric dental providers, willing to participate in the program. Majority of dentists (78.2%) are not enrolled as Medicaid providers. 71.9% dentists cite "inadequate reimbursement" as the main reason for not enrolling in Medicaid or accepting new Medicaid patients.[11] In 2020, FL ranked as the eighth lowest in dental **Medicaid reimbursement at 42.6% of private insurance reimbursement for child dental services**.[12] **In 2019, less than 1% of Florida's Medicaid spending was dedicated to dental services.**[13] Hence, access to dental care for Medicaid-enrolled CYSHCN is a major concern and in need of change.

Dentists who specialize in pediatric dentistry are more likely than general dentists to have the training and experience required to care for CYSHCN. Approximately 24.4% of dentists in FL are specialists and the largest number of specialists practices Orthodontics; **approximately 4% specialize in pediatric dentistry.** Evidence suggest that there are very few pediatric dentists serving Medicaid-enrolled children and those that do serve Medicaid-enrolled children limit the number of those children they serve due to social stigma[14] associated with providing care to Medicaid recipients. The dental education systems has failed to develop a workforce of dentists willing and prepared to treat the special needs population. Pediatric dentists along are not enough to meet the demands.

Furthermore, oral health care training and access strategies for the special health care needs population have largely remained unchanged. In 2017, the National Council on Disability (NCD)[15] released an issue brief which highlighted the findings that more than 50% of dental and medical school deans have stated that their **graduates are not competent to treat patients with intellectual/developmental disabilities.** Following the recommendations from NCD, in 2019 the American Dental Association (ADA)[16] revised its Code of Conduct, which also serves as a standard for state laws, to explicitly prohibit dental care providers from denying care to patients because of their disability; and in 2020 the Commission on Dental Accreditation (CODA) began requiring that all U.S. predoctoral dental education programs educate students on managing patients with special needs. These steps will better equip dental providers to care for patients with special health care need and disabilities. However, it will be years before we have a competent dental workforce at the necessary capacity to close the gap. Furthermore, without an attractive financial mechanism to incentivize the dental providers to treat and retain CYSHCN, oral health care for this population will remain unequal.

Expanding Oral Health Care Access to CYSHCN

Florida is facing a significant need for an accessible and affordable oral health care system that is staffed by educated providers, prepared and willing to treat CYSHCN. To foster long-term improvement and

sustainability, Florida must take an upstream, systems-change approach that requires more time and resource investment upfront.

FUNDING

Medicaid Reimbursement: Medicaid reimbursement rates are an important determinant of access to care, health care utilization, and health status among Medicaid beneficiaries. **Financial incentives have large implications for disparities in access to dental care.**

CASE STUDY: Texas

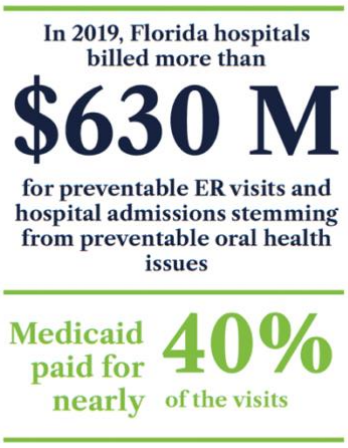
In 2007 Texas was ranked as a bottom 10 state in providing dental services to their Medicaid-eligible children. The same year, Texas appropriated $258.7 million to fund a 50% increase in dental reimbursement rates and $150 million to implement medical and dental initiatives such as mobile dental clinics in underserved communities and loan forgiveness programs for physicians and dentists.[17] A follow-up study found that from 2007 to 2011–2012, preventive dental care utilization among Medicaid-eligible children increased from 65.9% to 80.7% and unmet dental needs declined from 4.5% to 2.4%.[18] 67.3% of Texas Medicaid-eligible children ages 1 to 20 receive preventive dental services,[19] highest in the nation, compared to 39.4% in Florida. Today, dental Medicaid reimbursement for child dental services in Texas is 70.3% of the private insurance reimbursement and Texas is among top states providing preventive dental services to children enrolled in Medicaid.

Florida has the opportunity to capitalize on lessons learned and employ policy for best practices to significantly impact health outcomes for the most vulnerable children. **Increasing Medicaid reimbursements can be expected to have long-term positive effects on beneficiary utilization and provider participation and therefore the oral health outcomes of children with special health care needs** while expanding, enhancing, and strengthening the Medicaid program.

Dental Student Loan Repayment Program: Dental students face upwards of $250,000 to $300,000 in debt[20] upon graduation and often can't afford to practice in underserved area due to high payments and low-Medicaid reimbursements – especially true among Medicaid providers. In 2019, Florida signed into law the Dental Student Loan Repayment Program which presented an avenue to encourage dentists to practice in underserved and dental care health professional shortage areas (DHPSAs) but remained unfunded. If funded over 5 years, this program has the potential to help over 1 million patients[21] in these areas. Leaving the Dental Student Loan Repayment Program unfunded along with low-reimbursement rates perpetuates inequities in oral health.

Medical-Dental Integration (MDI): Oral health is often removed from the rest of health care. But the interconnections between oral health and overall health is increasingly clear. Poor oral health can contribute to a variety of other adverse health outcomes including cardiovascular disease, diabetes, obesity, dementia, poor respiratory health, poor mental health, and adverse birth outcomes.[17,22] Integration of dental care into primary and behavioral health presents an opportunity for primary care providers to help screen CYSHCN for oral health problems allowing for timely dental care and prevention of new oral health conditions and emerging health issues.

Individuals at highest risk for dental disease, including CYSHCN, Medicaid-enrolled and low-income, have the greatest difficulty accessing care. Integration of medical and dental services has become a key strategy to increasing care for vulnerable populations. Community health programs and FQHCs have traditionally led the way in developing and adopting various models to achieve integration. More than ever before, there is a need for MDI on the state level. Adopting and funding MDI as a standard of care in Florida has the potential to increase access and improve health outcomes for CYSHCN, while providing greater financial benefits to providers and maintaining state's fiscal health.



The refusal to recognize oral health as a critical component of overall health and lack of investment in evidence-based public health interventions, such as MDI and provider incentives, is costing Florida millions each year. Emergency departments (ED) have become a regular source of care for individuals with dental problems, particularly for those that are Medicaid-enrolled because there are few or no viable options other than the ED. It is estimated that the **rates of ED use are nearly 2-3 times higher among CYSHCN compared to non-CYSHCN.**[23] According to ADA Health Policy Institute, 69% of ED dental visits among children are paid for by Medicaid.[24] In 2019, Florida spent approximately $630 million on ED visits that could have been prevented by a trip to a dental provider.[25] Medicaid was the most common primary payer for dental-related ED visits, paying for over 40% of the visits. These trips are costly to the patients, Medicaid programs, taxpayers, and the overall health system.

Expanding policies, enhancing educational repayment programs, and investing in program and initiatives that value prevention and provide dental care to low-income and vulnerable is of the most importance.

EDUCATION

Person-Centered Care and Social Determinants of Health in Dental School Curriculum: Providing care to individuals with special health care needs requires specialized knowledge and skills, increased awareness and attention, and accommodation, beyond what is considered routine. Dental providers must be trained to properly treat and accommodate patients with special needs in an interprofessional and person-centered manner with didactic and hands-on training. This can help to prepare them to work with CYSHCN and identify and address oral health disparities. Oral disease, as any disease, is impacted by social, political, and behavioral factors. Social Determinants of Health (SDOH)[26] are an important mechanism to reducing health disparities and is key to mastering person-centered care as it can provide a better understanding of personal and structural barriers to achieving and maintaining good oral health. Dental institutions and programs must pivot their focus from solely treating dental disease to supporting the overall health needs of the patient and prioritizing both medical, dental, and social factors. Furthermore, dental schools in Florida must provide dental students with hands-on experiences treating children with intellectual and developmental disabilities, serios mental illness, desperate family situations and other special needs and vulnerabilities. Experiential learning can aid the providers to become familiar with a wide spectrum of disabilities and vulnerabilities, help them gain a broader perspective of potential drivers of poor oral health and better understand population health. Intertwining SDOH and person-centered care with interprofessional opportunities to apply the knowledge in dental curricula has the potential to improve health outcomes, increase health equity and improve patient satisfaction.[27]

Continuing Education and Professional Development: Online professional development courses and programs designed to help oral health professionals better understand treatment and practice techniques for CYSHCN should be incentivized for biannual licensure renewal. While CODA began requiring that all U.S. predoctoral dental education programs educate students on managing patients with special needs in 2020, it will be years before we have necessary capacity of dental providers with competence to treat CYSHCN. This requirement must be complemented with state legislature that incentivizes education credits about treatment and practice techniques of vulnerable populations, including CYSHCN, by increasing the rate at which these credits can be earned. These courses can be included as a subsection of the general hours subject area but incentivized with increased CE credits to motivate the providers to take the courses. This step will give dental providers and opportunity to obtain greater knowledge and competence in special needs dentistry thereby working towards achieving the highest standard of care in an equitable manner. Having enough oral health providers with competencies, skills and qualifications is critical to increasing access and reducing oral health disparities.

Conclusion

State policies can address critical issues of financing, education, and training. Disparities in access to dental care for special needs children continue to exist, especially among Medicaid-enrolled children. To increase access and maximize the utilization of dental services for CYSHCN, evidence-based interventions must be complemented with policies that increase funding and expand incentive mechanisms. This issue brief outlines recommendations for action and points out that Florida can make improvements. Further, this is an opportunity for the state to work creatively with organizations, dedicated to improving oral health services for children to significantly improve oral health outcomes for its most vulnerable populations. **The time to act is now!**

In partnership with Florida Oral Health Alliance (FOHA)

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