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Commentary

To work toward oral health care equity, start with Medicaid

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The COVID-19 pandemic and racial unrest in our country have shown us many things about who we are and who we could be. These transformative events should have taught us 2 things as scientist clinicians—the limitations of government and the societal inequities in health care. The politicization of revered and respected institutions like the Centers for Disease Control and Prevention and the National Institutes of Health cast a shadow on these agencies. Their inability to keep pace with the changing pandemic, and their subsequent overcompensation with opposing and occasionally fleeting directives, disappointed many in the dental community.[1] The pandemic's battering of already marginalized poor and minorities, with disproportionate death among people of color, brought home the divide in health and health care. Underlying health conditions, also a legacy of a fragmented health care system, made them especially vulnerable to the virus. This pandemic's scenario-pairing of the vulnerability of poor populations with governmental shortcomings is not unlike the pattern that places poor and minority populations at risk of developing dental disease.

Poor administrative policy and health care inequities converge in Medicaid, an essential program for those in poverty who experience dental disease. In the time of President Lyndon B. Johnson's Great Society, Medicaid gave hope for access and health care equity to many, but over its 50-plus years, it has failed to provide true oral health care parity for the neediest and most vulnerable in our society. In spite of some evidence of improvement in children's oral health care access,[2] Medicaid's overall track record remains marginal to poor, based on use, coverage of the most vulnerable, and dentist participation. Can Medicaid ever hope to provide oral health care equity to poor Americans?

This commentary proposes first steps in moving closer toward oral health care equity within the existing vehicle of Medicaid, which serves largely those with limited access to health care. True overall health care equity will require our society to address deep and longstanding social disparities and will take decades, but that is beyond the scope of this commentary. Negative social determinants of health remain prominent obstacles to health care equity, yet progress can be made to close the gap. Many of the same obstacles apply to the ultimate achievement of oral health care equity, but incremental improvement can be made, beginning with changes in existing programs helping the poor, like Medicaid.

We believe the following fundamental changes in Medicaid would begin to restore both hope for oral health care and trust in government among people who depend on Medicaid for oral health care.

RAISE DENTAL FEES

Leading off with a plea for fee increases may turn away some readers, but the literature is consistent and clear on the beneficial effect increases in traditionally low fees have on dentist participation in Medicaid.[3,4] If we accept that for the foreseeable future, Medicaid will depend on a dental care system comprising private practice dentistry and other business models designed around fee-for-service, irrespective of new provider types, it is hard to see a way to ensure equity without a fee structure competitive with that enjoyed by our privately insured population. In addition to perpetuating low provider participation, inadequate reimbursement for dental care affects operating room access, the financial viability of heavily indebted graduates' participation, the ability to perform case management for this challenged population, and the willingness of practitioners to enter environments in need of care, all translating to continuing oral health care inequity for

Medicaid-covered patients. In many states, fees have been stagnant for years, while real costs, including pandemic compliance, have increased.

Data from the American Dental Association Health Policy Institute suggest that dentists' Medicaid participation has been affected by the pandemic and continued participation is on the chopping block for some dentists experiencing financial distress.[5] COVID-19 has stressed state budgets, making fee increases challenging, but it should escape no one knowledgeable about Medicaid that a state Medicaid dental budget typically is a small fraction of its overall Medicaid budget. The amount needed to make Medicaid dental fees competitive with commercial dental insurance across the board is achievable. In the United States overall, dental Medicaid expenditures are about 4% of the Medicaid budget.[2] If we believe that all people have the same right to care, it is hard to ethically justify this discrepancy in reimbursement that creates and perpetuates dental haves and have-nots.

Nowhere is the tragedy of low reimbursement more evident today than in the inability of pediatric dentists and oral surgeons to gain hospital and surgical center operating room access. This growing problem[6] has been exacerbated by the COVID-19 pandemic[7] and stands to get worse[8,9] as cases mount in number, even with declining pandemic infections, due to backlogged cases. Hospitals cannot continue to provide operating room access to dentists at the Medicaid facility fee reimbursement rate in many states. In addition to dental procedural reimbursement well below commercial reimbursement,[10] facility fee reimbursement to hospitals for dental care under general anesthesia is a fraction of that for a general surgical procedure, a national average of just over $200 versus well over $2,000.[11] The pandemic has worsened the financial status of already struggling hospitals. The care of young children in poverty with severe early childhood caries and adults with special needs is being forced into potentially less safe environments or avoided altogether.

As a largely private practice dental community and one likely to remain as such for the foreseeable future, we often forget that our system encompasses public health and nongovernmental not-for-profit care delivery entities that depend on Medicaid to stay afloat. These necessary sources of care, reaching noncovered sandwich populations, suffer as Medicaid fees decline in relation to real costs, forcing many to close. Fee increases or other major changes in Medicaid reimbursement are not likely in view of pandemic-devastated state budgets and federal gridlock,[12,13] but the potential for equity and improved access to care that comes with competitive fees cannot be denied.

For those in government, the fee differential may represent good fiscal management; but for many in dependent communities, it is a statement on how society values them. Increases in dental fees in Medicaid benefit patients in this system far more than the dentists who treat them.

FIRST, FIX WHAT IS BROKEN

A 2020 letter about innovation with value-based care[14] from the Centers for Medicaid & Medicare Services to state Medicaid directors speaks to the disconnect between government and the people who depend on it for care. It is not assured that dentistry will experience significant improvement in outcomes if the fee-for-service system is exchanged for a value-based one. California's expensive experiment with value-based care innovation has had ho-hum results so far.[15] With many states operating under some form of Medicaid managed care systems, we ought to have seen consistent improvement, but that has not been the case. The incentive for, and outcome of, this administrative shift to managed care seem to have been cost control for states and not increased use by patients or participation by dentists.

In the minds of many minority Americans, ill-conceived medical experimentation is still symbolic of our government's approach to their health.[16] This is evident today in COVID-19 vaccine hesitancy among people of color[17] and vaccine distribution plans that do not account for life expectancies of minorities. Experimentation with Medicaid should not be borne by those who depend on it for care and health. Capitation, managed care, and now value-based care are examples of innovations that have not succeeded in improving oral health in the United States. Michigan's Healthy Kids Dental Program,[18] which increased reimbursement and integrated Medicaid dental care into the private mainstream almost 2 decades ago, was innovative and has been successful. It was less experimental than it was reparative, integrative, and confirmatory of basic principles of minimal government and of the strengths of the private practice health care system. The net result was better access to care.

EXPAND ADULT DENTAL MEDICAID

Evidence supports engaging adults in Medicaid.[19,20] A large wave of adults who do not seek regular dental care[21] will likely eventually need it. Many have experienced pandemic-related unemployment. Without access to dental care, poor patients are relegated to hospital emergency departments for care, often beyond that system's capacity and capability; Medicaid coverage reduces that.[19] Dental access for seniors in Medicare, if that becomes reality, will bring with it a large segment of the population having had limited oral health care services and a lifelong accumulation of oral and systemic illness.[21] This is supported by a CareQuest report on oral health care equity,[22] which indicates that 4 in 10 Black and Hispanic adults live in states without adult Medicaid benefits or with just emergency dental benefits, representing groups already experiencing diminished access to care. Furthermore, children with special needs rely on Medicaid and will eventually reach adulthood because of improved survival. Without dental coverage, their already difficult search for oral health care as adults[23] will be magnified. A robust adult Medicaid dental benefit would add only about 1% to a state's overall Medicaid budget.[24] Having adult dental benefits does not guarantee use, but it is a foundation for improvement in oral health care across the life span and brings us a step closer to oral health care equity.

ENGAGE THE COMMUNITY

One look at many urban streets of this country's cities at night on the national news shows that top-down decision making has marginalized segments of our society on many social issues. Community-based decision making encourages people within the environment to craft solutions and use the assistance—not direction—of experts. The Medicaid community is a large and diverse pyramid with a large base of client membership and a tip made up of those far removed from the realities of the base's life challenges. Also within that pyramid are dental professionals, social service agencies, charitable organizations, case and community workers, and others close to both problems and potential solutions. It is past time for Medicaid to engage those who receive, those who serve, and those who make Medicaid work in its decision-making process at all levels.

A 2019 Medicaid auditing debacle in Nebraska,[25] which threatened an already overburdened care system for poor rural children, exemplifies the detachment of high-end administrative decision makers from realities faced by clinicians who care for these patients and have to live with their care decisions. In spite of professional guidelines on best practices and evidence on restoration longevity, the government auditors chose to apply antiquated and unproven audit criteria that led to decisions against dentists committed to care of the poor. Ironically, it was grassroots action by those engaged in and knowledgeable about Medicaid and the population it serves that corrected that wrong.

The pandemic's revelations should focus decision makers on listening to those closer to oral health care inequity, including patients, committed dental clinicians, and boots-on-the-ground social activists, to craft solutions that work. This is not a new concept, nor is it one confined to grassroots Medicaid.[26] It is time for this to happen in dental Medicaid if we really are committed to equity.

WE NEED A MEDICAID HOMESTEAD ACT

While Washington trumpets value-based care and more states move to curb costs with managed care arrangements for Medicaid, little attention has been focused on the differences between US medical and dental systems and the impact on patients when one-size-fits-all decision making is applied to dental Medicaid. Medical care in the United States is a "system of systems," whereas dental care is a "system of small businesses." Economies of scale, mandated quality assurance, numerus regulations like the Emergency Medical Treatment and Labor Act,[27] and a host of other differences make dentistry and medicine poles apart when it comes to entitlement care.

If we are serious about improving equity in oral health care, these differences need to translate to incentives that bring providers to Medicaid. The work of the American Dental Association Council on Advocacy for Access and Prevention's Medicaid Provider Advisory Committee to interest future dentists in Medicaid participation can be negated in a heartbeat by unfair robotic audits, Medicaid credentialing and billing barriers, and graceless comments about Medicaid patients by nonparticipating dentists. It is time to fuel participation by incentives beyond just reasonable fees, with bolder actions like tuition payback based on Medicaid care participation, fee incentives for rural practice

establishment, increased fees tied to care in needy microenvironments and with special needs populations, preferred prior authorization status, fast-track credentialing, and other creative ways to credit dentists who provide Medicaid care. The Health Resources and Services Administration's review of Health Provider Shortage Areas, currently underway, offers an opportunity to pilot a homesteading of dental providers to care for Medicaid patients. Care deserts will likely continue to exist for the Medicaid population, yet they could be reduced with bold action to incentivize Medicaid provider participation.

CONCLUSIONS

We offer these suggestions after our combined century or more of caring for people in the Medicaid system in various states and watching medicine reach these same patients with both innovation and resolve to try to achieve health equity. The concept of focusing on Medicaid has been raised before by advocates and would advance equity in oral health care in the system originally designed to achieve it. Our medical colleagues, major philanthropic organizations, and the public have also looked toward Medicaid as a portal to begin to rectify wrongs and improve the health of disenfranchised Americans.[28-30]

We share the same commitment as our pediatric dentist colleagues who overwhelmingly choose to seek oral health care equity for all children.[31] We invite all of dentistry to join the majority of pediatric dentists to pursue this same goal and work with Medicaid at all levels to transform the system to achieve its original promise of oral health care equity for those it serves.

It is well beyond time for all of dentistry to escape the convenient culture of believing that some care is better than no care and set our sights on true oral health care equity. ■

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