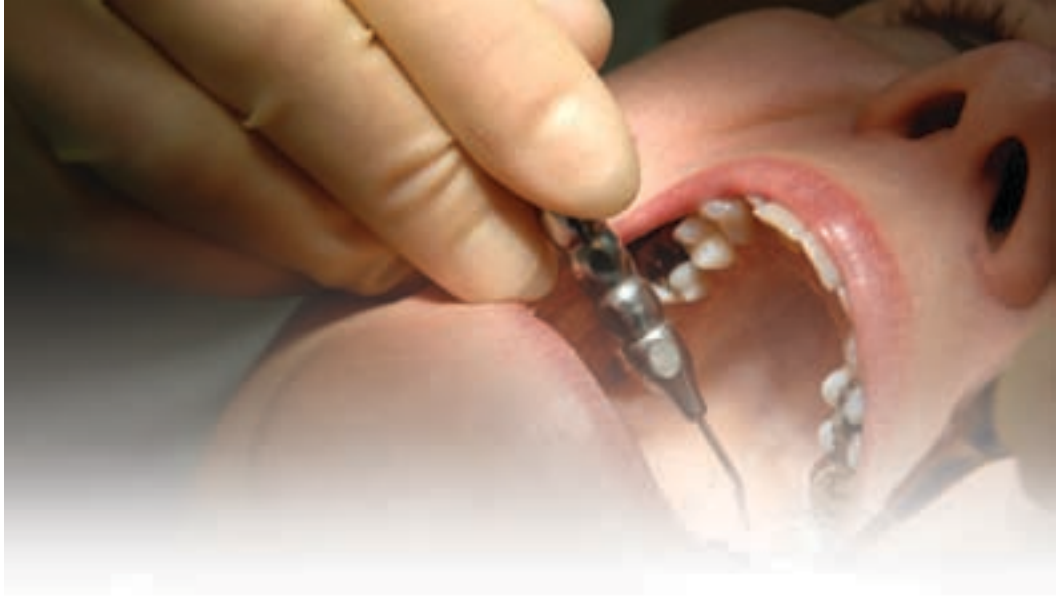

The Patient Protection and Affordable Care Act
Effects on Dental Care

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Abstract

Health care reform has been a subject of debate long before the presidential campaign of 2008, through the presidential signing of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, and is likely to continue as a topic of discussion well into the future. The effects of this historic reform on the delivery of healthcare and on the economy are subject to speculation. While most people are at least generally aware that access to medical care will be improved in many ways, few people, including many in the dental profession, are aware that this legislation also addresses oral health disparities and access to dental care. It is the purpose of this paper to review how dental care is currently accessed in the United States and where oral health care disparities exist, to suggest approaches to alleviating these disparities and to delineate how the changes in dental policies found in the PPACA hope to address these concerns. The main arguments of organized dentistry, both those in support of and in opposition to the PPACA, are summarized.

HEALTH CARE REFORM has been a subject of debate long before the presidential campaign of 2008, through the presidential signing of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, and is likely to continue as a topic of discussion well into the future. The effects of this historic reform on the delivery of healthcare and on the economy are subject to speculation. While most people are at least generally aware that access to medical care will be improved in many ways, few people, including many in the dental profession, are aware that this legislation also addresses oral health disparities and access to dental care. It is the purpose of this paper to review how dental care is currently accessed in the United States and where oral health care disparities exist, to suggest approaches to alleviating these disparities and to delineate how the changes in dental policies found in the PPACA hope to address these concerns.

Background

The problem of oral health disparity and access to dental care were highlighted by a number of events, among them, the release of a pivotal report by the surgeon general entitled "Oral Health in America: A Report of the Surgeon General"[1] in 2000, followed by a second report in 2003 entitled "A Call to Action to Promote Oral Health."[2] Simultaneously, there was an erosion of state Medicaid programs, leading to decreased reimbursement for dental care and a subsequent decrease in participating dentists, and little-to-no adult coverage in many states.[3] There was a well-publicized 2006 lawsuit brought by the American Dental Association and the Alaska Dental Association against the Alaska Native Tribal Health Consortium over the training of mid-level dental practitioners—dental health aide therapists—and high-profile tragedies that included the death of a 12-year-old Maryland boy as the result of an untreated dental infection.[4,5] The debate on PPACA called attention to these issues as organized dental communities weighed in on how dentistry should be involved in this historic legislation.

Dental care in the United States is provided predominantly through private practice. Wendling has summarized that as of 2007,

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there were 181,725 active dentists in the U.S.; of these, 166,837 were in private practice.[6] The article states that roughly two-thirds of the U.S. population accesses the private practice delivery system over a given 12-month period. "This is a market-based delivery system, owned and run by professionals and regulated at the state level composed primarily of dentists in private practice who are paid by third party payers or directly from consumers."[7]

The remaining one-third of the population experiences difficulty in accessing care through the traditional fee-for-service private practice model. This is because of the maldistribution of dentists, low or no Medicaid reimbursement and lack of personal dental insurance (up to 43% of the population).[8] These patients are more likely to have higher rates of decayed teeth and more advanced periodontal disease and other pathology, complicating the delivery of care.[6,9,10]

The segment of the dental profession that provides care to the most needy comprises the "dental safety net." The dental safety net includes hospital, dental school and dental hygiene school clinics; health centers; for-profit Medicaid dental practices; hospital emergency rooms; Veterans Administration hospitals; prison dental clinics; Indian Health Services; and volunteer dental programs. In addition, 20%, or about 30,000 private and group practice dentists in the United States, are Medicaid providers.[11] The separate pieces of the safety net are loosely organized, variable in program content and policy, and fail to meet current needs of the population.[11]

In 2009, in light of the coming Health Care Reform Bill, the Institute of Medicine (IOM) held a workshop entitled "US Oral Health Workforce in the Coming Decade" to discuss existing trends in dentistry and to offer suggestions on how the needs of the underserved might be met in the future.[12] These ideas were later published as a series of papers in a special edition of the Journal of Public Health Dentistry.[3,6,8,9,11,13,14] These papers addressed the design of an ideal oral healthcare system, with emphasis on improving access to care in rural and urban areas and institutional settings and making improvements to the dental safety net in general. The problem with access was underscored by noting that in 2007, there were 4,230 dental health professional shortage areas identified in the United States.[8] It was estimated that it would take 9,642 additional practitioners to meet the needs at that time—and that does not take into account the huge influx of children who will, theoretically, soon be covered for dental care under the PPACA.

One suggested solution is to emphasize the cost-effective technique of preventing dental caries and periodontal disease. Prevention education could be performed by dental auxiliaries, including dental hygienists and expanded duty dental assistants (EDDAs). The ADA proposed creating a community dental health coordinator (CDHC). The CDHCs would, preferably, be people from the community trained to teach prevention and tobacco cessation and to facilitate access and utilization of dental diagnosis and treatment and who would return to serve their community in these capacities.[6]

Perhaps the most controversial of all the suggested access-to-care improvements is the development of the "mid-level" practitioner. This includes using dental hygienists and dental assistants in new ways and creating new types of providers, including:

- The previously mentioned CDHC proposed by the ADA.
- The advanced dental hygiene practitioner (ADHP), an advanced education, master's level practitioner who can perform restorative procedures, pulpotomies, temporary crowns and simple extractions.[8]
- The dental therapist or dental health aid therapist (DHAT), a person with two years post-high school experience who performs restorative procedures, pulpotomies, temporary crowns and simple extractions of primary teeth. These therapists work under the general supervision of a dentist and on collaborative teams. The model is currently used in rural areas of Alaska.[8]
- Nurse practitioner model, a person who works collaboratively with a dentist in a private dental office and becomes part of a healthcare team, so the patient can have both oral healthcare and primary healthcare delivered.[8]

PPACA Specific to Dental Care

In response to the access-to-dental-care problems and the suggested solutions to them, the Patient Protection and Affordable Care Act authorizes, within its 2,500 or so pages, several major changes in policy and funding as relates specifically to dental health. These policy issues are discussed in detail in other publications and are briefly summarized in Table 1.[15,16]

Policy Arguments

From the Obama/McCain presidential campaign through passage of the PPACA, there were a number of special interest dental groups working behind the scenes on healthcare reform. Some of these groups included the American Dental Association (ADA), American Dental Hygienists Association (ADHA), Academy of General Dentistry (AGD), American Academy of Oral and Maxillofacial Surgeons (AAOMS), American Academy of Pediatric Dentistry (AAPD), Children's Dental Health Project (CDHP) and several other smaller organizations. Some of these groups supported the PPACA, largely based on one or two issues, while others offered broad support for the legislation. Most of the major dental organizations opposed the legislation, based on several key issues.

TABLE 1

Summary of Major Provisions of PPACA Affecting Dental Care[15,16,20]

1. In order for a "qualified health plan" to be able to participate in the Healthcare Exchange, it must include (among other provisions) "pediatric services, including oral and vision care." (The legislation notably leaves out any required coverage for adults.)

2. Each state is permitted to allow insurance companies to offer the pediatric dental benefit through a stand-alone plan or in conjunction with a qualified health plan as long as the plan contains the essential dental health benefits required by HHS.

3. The Medicaid and CHIP Payment and Access Commission (MACPAC) is charged with review and the updating of payments to dental professionals. (The legislation notably leaves this as a gray area.)

4. Medicare Advantage plans generally paid more than comparable services in the Medicare Fee for Service plans for comparable services. These additional payments in some cases paid for dental services. The PPACA requires that the higher payment first be applied towards cost-sharing reductions, second toward wellness and preventive care and, lastly, toward extra benefits not available in FFS plans, including dental coverage.

5. The bill supports the creation of various "Oral Healthcare Prevention Activities," including funding for:

   a. A national public education program on prevention of oral diseases such as periodontal disease and caries that must be targeted to specific groups: e.g. elderly, pregnant women, children, disabled and minorities.

   b. A research-based dental caries management program provided to community-based dental providers, including the Indian Health Service.

6. School-based dental sealant programs.

7. Establishment of "oral health leadership and program guidance" through the Centers for Disease Control (CDC).

8. Updating and expanding the CDC's National Oral Health Surveillance Programs to be required in all 50 states, including:

   a. The Pregnancy and Risk Assessment Monitoring System.

   b. The National Health and Nutrition Examination Survey.

   c. The Medical Expenditures Panel Survey.

9. Grants for school-based health centers, including "referrals to and follow up for oral health services."

10. Medically accessible equipment for the disabled, including that found in dental offices.

11. Health workforce provisions, including:

   a. Creating new "dental cluster" health training programs to include, general, pediatric, public health dentists and dental hygienists. This provision allows grants to pay for student and resident training, financial assistance, program development, loan repayment for students and faculty and the provision of technical assistance in pediatric dental training programs.

   b. Establishment of "demonstration projects" for "alternative dental health care providers, including CDHCs, Advanced Practice Dental Hygienists, Independent Dental Hygienists, Supervised Dental Hygienists, Primary Care Physicians, Dental Therapists, Dental Health Aids or other as deemed appropriate by the Secretary of the HHS.

12. New and expanded "teaching health centers" to train primary healthcare providers, including dentists, in general and pediatric residencies in ambulatory patient care centers.

13. There are also a number of other issues that affect small business and, therefore, private dental practices but are beyond the scope of this paper.

In Favor of PPACA

Among those dental groups that supported the legislation, the CDHP seemingly was centrally involved in shaping the final dental provisions of the bill. The group's mission, "creating and advancing innovative solutions to achieve oral health for all children," was brought much closer to realization by passage of the legislation.[17] The legislation will provide dental coverage to virtually all children (with the exception of illegal aliens) and through other provisions, at least in theory, will dramatically improve access for that treatment.

Workforce grants supporting the development of mid-level practitioners and Title VII grants for dental resident and dental hygiene programs will help expand access. Grants for school-based health centers will provide dental care, and the standards set for access for those with disabilities fall squarely within CDHP's mission. Public education programs, school-based dental sealant programs and dental caries management form a low-cost way to dramatically improve oral health. CDHP termed this a "systems fix" approach, where prevention and management intervention will occur at community, family and individual levels.[17] It is also notable that the CDHP is the only dental organization, to the authors' knowledge, that advocates for the public and, specifically, for children and does not represent the profession.

Other dental organizations, representing different facets of the dental profession, were more one-dimensional. The ADHA supported the legislation mainly because of the funding provided for "alternative dental providers" and the funding specified under Title VII for training dental hygienists (in addition to the funding for dental residents, practicing dentists and dental students).[18] The Hispanic Dental Association, while opposing support for developing the mid-level practitioner, supported the legislation in general with the focus on access to care for the underserved. The National Dental Association, an organization representing mainly black dentists, supported the legislation, but made an argument against a two-tiered system, whereby the poor and minorities, who often present with the most advanced and complex problems, would be treated by practitioners with less training.[16]

Opposed to PPACA

The most prominent organization of the dental profession is the ADA, representing some 160,000 dentists. The ADA was involved with lobbying efforts, but ultimately opposed the legislation based on three major

issues summarized in a letter to Speaker of the House Pelosi and signed by the ADA and six other dental organizations that govern most of the dental specialties (not including the specialties of public health, endodontics and radiology) and the AAPD.[19] Below is a summary of their arguments against the bill:

1. Medicaid funding for dentistry is not properly addressed. Without increases in reimbursement to dentists, the legislation will increase the number of covered children, which will increase demand for services but will not increase the supply of dentists who can afford to treat these patients. They also expressed concern about continued Medicaid administrative barriers and a lack of data-gathering initiatives to help improve Medicaid coverage.
2. No basic adult dental benefit was addressed, so adults in underserved communities will continue to have difficulty accessing dental care.
3. They argued against the funding for development of the mid-level practitioner model calling it, in effect, a two-tiered system, whereby dental care would be provided to the underserved by non-dentists with less training. They also expressed concern about the use of Title VII funds, formerly reserved for dental residents and partially for training dental hygienists.

The AGD, the largest organization supporting general dentists, published a lengthy white paper, which argued against mid-level practitioners.[20] In addition to some of the arguments previously stated, the AGD asserted it would be unlikely for these practitioners to create economically viable offices or clinics. The academy also expressed concern for the health and safety of the patients they treat (an assertion not supported in the literature); and it argued that access could better be improved through tax credits to dentists working in underserved areas, scholarships to dental students who agree to practice in an underserved area and recruitment of dental students from underserved areas, who would have a higher likelihood of returning to practice in those areas.[15]

AAOMS, the largest organization representing oral and maxillofacial surgeons, opposed the legislation on similar grounds; it was especially opposed to the mid-level practitioner having the privilege of tooth extraction.[16] In addition, it shared concerns about a lack of adult coverage, the vagueness of what will be covered for children (especially the removal of wisdom teeth) and the lack of improvement in reimbursement rates.

Although there is no doubt that PPACA has gone further than any other government program to alleviate oral health care disparities in this country, it will likely fall short of the expectations of its supporters.

Passage of this bill provides authorization for its provisions but does not guarantee funding. Funding is a highly political issue that

will change with time. Some of the pieces of this legislation do not become operational until 2014, most notably, the state insurance exchanges, along with the mandated provision of essential oral health benefits. The 2010 mid-term elections produced dramatic changes in national and state governments, a shift from Democratic to Republican control in many cases. With the serious financial issues facing the country, appropriating funds may not be so easy. Cuts in some of the provisions of the PPACA are likely. Provisions of the bill will also be affected dramatically at the state level with the election of many more Republican governors.[21]

School-based centers providing oral health services, along with school-based sealant programs, may help with access to care, but children in underserved areas often have significant dental disease before school age and need emergency dental intervention,[10] so earlier access, perhaps at 1 year of age, would be preferable. On a positive note, the public education campaign for parents and children is an inexpensive and powerful way to improve oral health of the underserved.

The mid-level practitioner effort will likely experience difficulty. Because the legislation specifies at least seven different entities, the $15 million dollars of funding over five years will be quite sparse for any one program. These different groups will have to compete with each other to get established and will, at best, be small movements relegated to limited geographic areas. There is a mandate that each program be accredited by the Commission on Dental Accreditation (CODA), which is a complex and lengthy process.

Conclusion

This paper discusses the current status of the provision of dental care and the problems in providing care to the underserved. Approaches to improving access to dental care were reviewed, along with a summary of the oral care provisions in the PPACA. The organized dentistry arguments both for and against these provisions were summarized and the authors' argument that health care reform will fall short of expectations of its proponents in the oral health care arena was presented. The reasons for the shortfall include likely political difficulties in appropriations at the federal and state level, given the change in government and the poor economy; failure to address the low fees for dental care from Medicaid; difficulties in changing state dental practice acts; and oversight nationally by CODA. ■

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