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Limitations in Access to Dental and Medical Specialty Care for Publicly Insured Children

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Editor's note: Medicaid and the state-run Children's Health Insurance Program (CHIP) cover about 42 million children, many of whom would not have access to care without public insurance. Federal law requires that this access be equivalent to that of privately insured children for covered services, and many states have implemented policies to improve longstanding disparities in primary and preventive care. Reimbursement rates are up, but significant disparities remain, especially for dental and specialty services. It is important to understand the distinct effect of provider-related barriers, because they are potentially more modifiable through health policy than patient-related ones. This Issue Brief summarizes research that directly measures the willingness of dental and medical providers to see publicly-insured children, using research assistants posing as mothers calling for an urgent appointment for their child.

Medicaid and CHIP have improved access to primary care, but access to dental and specialty care lags behind

In many ways, Medicaid/CHIP has succeeded in its goal of reducing financial barriers to care for low-income children. A 2010 Department of Health & Human Services report noted that children covered by Medicaid/CHIP have access to primary care that is comparable to privately insured children and better than uninsured children. However, significant barriers to dental care and specialty care remain.

- According to the U.S. General Accounting Office (GAO), about 38% of children ages 2-17 on Medicaid/CHIP saw a dentist in the previous year, compared to 55% of privately insured children and just 26% of uninsured children. Possibly because of this disparity in access, children on Medicaid/CHIP were more than four times as likely as privately insured children to need urgent dental care.
- The GAO also found that 24% of families with children 17 and under on Medicaid/CHIP reported problems seeing a needed specialist, compared to 18% of privately insured children and 29% of uninsured children.
- These disparities conflict with state goals and federal law. States are required, by federal law, to ensure that Medicaid recipients have access to care "at least to the extent that such care and services are available to the general population in the geographic area." These disparities in access can stem from overall provider supply and distribution, provider unwillingness to accept Medicaid/CHIP, and lack of patient/family resources such as income, education, language proficiency, and health literacy. Teasing these factors apart may lead to more effective solutions to address relevant barriers to care.

Illinois faced class-action suit because of disparities in its Medicaid program for children

In 1992, a class-action suit was filed on behalf of Cook County children enrolled in Medicaid, alleging wide disparities in access to primary and preventive care. In a landmark settlement in 2005, Illinois agreed to increase Medicaid reimbursement rates for well-child medical and dental services. Illinois is one of 27 states implementing Medicaid and CHIP as a combined program under one name.

- As of January 2006, reimbursement rates for primary and preventive care increased significantly, often doubling. The state also implemented a primary care case management program, which currently serves 67% of publicly insured children in Cook County. The remaining children are serviced in a fee-for-service structure (16%), or managed care organizations (18%).
- Preventive dental care payment rates increased to the same level as the state employees' dental plan.
- The court-ordered Consent Decree also required the state to fund studies of outpatient specialty medical and dental care to measure access to these services. The "audit" studies described in this brief are the result of this mandate. This methodology can be used to directly measure provider willingness to accept public insurance, holding all other clinical and patient-related factors constant.

In the dental audit study, research assistants posed as mothers calling for an urgent dental appointment for child with a fractured permanent front tooth

Historically, audit studies have been used to measure discrimination in labor and housing markets. This study included 41 practices enrolled in the state's Medicaid/CHIP dental administrator program (DentaQuest) and 44 that were not.

- Between February and May 2010, research assistants called dental practices and posed as mothers of a 10-year-old boy needing urgent dental care. They made two calls to each practice, one month apart, with the same clinical scenario. The only difference was the child's insurance status (Medicaid/CHIP vs. private Blue Cross coverage).
- The mothers said that they had been referred from an emergency department because their child had a symptomatic (painful) fracture of a permanent front tooth. This clinical scenario was chosen because it is a common dental condition warranting timely treatment, ideally within 24 hours. Each caller tried to schedule an urgent appointment with the dental practice. All scheduled appointments were cancelled after the call.

Study reveals large disparities in access to urgent dental care for publicly insured children

Children needing urgent dental care were much less likely to obtain a dental appointment if they had public versus private insurance. This was true even in dental practices enrolled in the Medicaid/CHIP program.

- Medicaid/CHIP-enrolled dental practices turned away 31.7% of children with Medicaid/CHIP, whereas they scheduled appointments for 100% of the Blue Cross-insured children. Non-enrolled dental practices turned away 93.2% of Medicaid/CHIP children and 9.1% of Blue Cross insured children.
- In analyses of calls to the same practice, enrolled dental practices were 18.2 times more likely to deny an appointment to a Medicaid/CHIP-insured child than the Blue Cross-insured child, and non-enrolled practices were 38 times more likely to do the same.
- Of those who obtained an appointment, children on Medicaid/CHIPS had an average wait time of 6.3 days, compared to 2.6 days for Blue Cross-insured children.
- Medicaid/CHIP callers denied an appointment asked about the possibility of paying cash. Non-enrolled practices then offered an appointment to 88.6% of these callers, requesting an average payment of $90 on the day of the visit. Enrolled practices (which are not permitted to charge Medicaid/CHIP patients) offered a cash appointment to 22% of the callers, requesting an average payment of $124.

Same methods used to measure access to specialty care for publicly insured children

Bisgaier and Rhodes used the same methods to identify disparities in medical specialty care for children with public insurance. The study involved 546 paired calls to 273 specialty clinics, representing eight specialties. Each caller reported having a referral from a primary care physician (PCP), and in some cases from an emergency department (ED) for a clinical condition that warranted timely outpatient evaluation and treatment. The following table lists the clinical scenarios for each specialty call:

Subspecialty Type (# of clinics)	Condition	Child's Age	Reported Symptoms
Dermatology (45)	Severe atopic dermatitis	9 months	Severe itchy rash for 7 months on face, legs and arms; PCP has tried steroids
Otolaryngology (43)	Obstructive sleep apnea and chronic bilateral otitis media	5 years	Snores every night but getting worse, fluid in both ears, frequent infections
Endocrine (23)	Type 1 diabetes	7 years	Tired, constantly thirsty, PCP tested fasting blood sugar (~200)
Neurology (37)	New onset afebrile seizures	8 years	Had a seizure last week, did not have fever, seen in ED
Orthopedics (40)	Forearm fracture through growth plate	12 years	X-ray in ED showed possible fracture, but doctors were not sure
Psychiatry (41)	Acute, severe depression	13 years	Withdrawn, depressed, grades slipped
Allergy/Immunology/ Pulmonary Disease (44)	Persistent, uncontrolled asthma	14 years	Takes many medications but still wheezes, using inhaler daily, seen in ED

Study finds significant disparities in all specialties

Across all specialty clinics contacted, children on Medicaid/CHIP were 6.2 more likely than privately insured children to be denied an appointment. And even when they received an appointment, the waiting time was more than double that of privately insured children. In all cases, the appointments were requested for conditions requiring urgent attention.

- Overall, 65.6% of Medicaid/CHIP children were denied an appointment, compared to 10.6% of privately insured children. The disparity between publicly and privately insured children existed for every specialty, with the largest disparity in orthopedics (80% vs. 2.5% turned away) and dermatology (71.4% vs. 4.4% turned away).
- When calls to the same clinic were analyzed as matched pairs, there were 155 pairs in which the clinic scheduled privately insured children but not Medicaid/CHIP children, and 5 in which Medicaid/CHIP children obtained an appointment and privately insured children did not.
- Among the 89 clinics that accepted both types of insurance, the average wait time for Medicaid/CHIP children was 22 days longer than for privately insured children (42 days vs. 20 days).

POLICY IMPLICATIONS

These studies document disparities in access to pediatric dental and specialty care for children with public insurance. It is well-established that reimbursement levels influence providers' decisions about whether to accept public insurance. Although raising reimbursement rates is important, other system or workforce-related issues may come into play, especially for dental services. These issues are particularly important because approximately half of the expansion in access promised through the Affordable Care Act is provided through an expansion of Medicaid.

Oral Health Policy

- An expert dental panel convened in Illinois recommended a multiple-prong strategy for improving access to urgent dental care under Medicaid/CHIP. First, it suggested increasing reimbursement rates for dental restorative procedures to 70-80% of Usual, Customary, and Reasonable (UCR) fee levels. For example, a dental crown procedure is reimbursed $235 by Medicaid/CHIP, compared to $917 by private insurance.
- Second, it suggested that the increased payments be implemented as part of a Dental Home Initiative that enrolls children with a dentist for oral health needs.

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POLICY IMPLICATIONS
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- Third, it suggested expanding and diversifying the dental workforce. It noted that many parts of Cook County have been designated as Dental Health Professional Shortage Areas (having less than 1 dentist for every 3,000 people). The panel recommended expanding the scope of practice for dental hygienists, and/or allowing advanced/alternative dental providers to offer services in federally certified underserved areas. Last year, Minnesota became the first state to authorize an expanded scope of practice for dental hygienists and advanced dental hygienists.

Pediatric Medical Subspecialty Policy

- In Illinois, an office visit for a problem of moderate severity is reimbursed at about $100 by Medicaid/CHIP and $160 by a commercial preferred provider organization. Reimbursement rates should be raised, but is it more effective to raise rates for all specialists, or to provide targeted incentives to specialists located in low-resource areas and committed to being safety-net providers? More work is needed to understand the benefits and opportunity costs of potential policy changes.
- Even callers claiming to have private insurance faced an average wait time of 20 days when urgently requesting an appointment. Cook County has an abundance of specialists (218 for every 100,000 population, compared to the national median of 32 for every 100,000). These findings signal a need to consider refining the delivery of specialty care to more efficiently use the specialist workforce, and improving coordination between generalists and specialists.

This Issue Brief is based on the following articles: J. Bisgaier, D. Cutts, B. Edelstein, K. Rhodes. Disparities in child access to emergency care for acute oral injury. Pediatrics, June 2011, vol. 127, pp. e1428-1435; J. Bisgaier, K.V. Rhodes. Auditing access to specialty care for children with public insurance. New England Journal of Medicine, June 16, 2011, vol. 364, pp. 2324-2333. A full report describing the methodology of this 3-year study has been sent to the state of Illinois Department of Healthcare and Family Services and will be publicly available on its website.

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