Fixing Medicaid

Medicaid can be made to work. But it will not unless enough dentists lead parents, advocates, bureaucrats and legislators into the serious work that can turn Medicaid's promise into performance and a Medicaid card into meaningful dental care. Ironically, there is no better scope of dental coverage for children than Medicaid's "EPSDT" but no worse card to carry when trying to obtain care. The disparity between what could be and what is could be eradicated if we learned to champion our issue just as the vaccine advocates, the teen pregnancy prevention advocates, the lead poisoning prevention advocates and the infant hearing screening advocates have done so effectively in recent years. The road is well marked but we have yet to walk it in effective numbers.

The very word, "Medicaid", elicits emotional responses from pediatric dentists—responses ranging from frustration to anger and now increasingly from cautious optimism to hope. The reason a 33-year-old publicly funded program that insures poor children elicits such frank emotion is because pediatric dentists are conflicted between caring for children and not caring for the program.

Because pediatric dentists care about children, many suffer when they know that children suffer. For Medicaid children who represent one in every four US citizens under the age of 21, suffering takes the form of higher disease rates, lower treatment rates, and more common bouts with dental pain and its consequences. For aware dentists, suffering sometimes takes the form of tolerating unfair Medicaid fees, inconvenient program administration, and often unsettling parental behaviors. For other dentists, suffering sometimes takes the form of anguished decisions about whether to continue treating Medicaid patients, or guilt over leaving them in the lurch. Some dentists, however, do not suffer at all because they have become completely unaware of the plight faced by these millions of children who find no care available.

Frustration yields to blame. Parents and programs blame dentists. Dentists blame Medicaid for failing kids. They blame parents for lack of responsibility. Finally, they blame each other either for participating and thereby curtailing pressure on the program to reform or for not participating and thereby punishing children. Yet blame is empty and counterproductive since blame never elicits change.

Change begins when a problem gets attention. Over the past two years, dental Medicaid reform has received more attention than during any period since its inception under Lyndon Johnson's Great Society. In 1996, a damning report from the Department of Health and Human Services claimed that only 1 in 5 Medicaid eligible children receives any preventive dental service in a year. Shortly after, Congress enacted the Child Health Insurance Program (CHIP) that forced states to scrutinize their Medicaid programs and thereby realize that Medicaid wasn't delivering on dental care. Subsequently, the "Tahoe" conference brought public officials and dental leaders together to identify barriers and recommend change. Then the federal Oral Health Initiative rebuilt a dental presence in the agency that runs Medicaid and developed a comprehensive effort for Congressional consideration. In 2000, the US Surgeon General will convene a Workshop and Conference focused exclusively on disparities in access and oral health status of children. Every national meeting of state legislators, public health officials, maternal and child health directors, Medicaid officials, and state dental directors in the last twelve months has dealt with dental Medicaid reform. The American Dental Association has convened its first ever conference on improving Medicaid access. The Reforming States Group, a federation of state policy makers concerned with health issues, has released an actuarially sound model to reform Medicaid. The Milbank Memorial Fund and Mayday Foundation have championed the idea that no child in America should go to bed with dental pain just as no child should be allowed to go to bed hungry. US Senator Jeff Bingaman has called for increased federal funding of dental Medicaid. The press has brought the issue to the public. For the first time appropriate accountability and program performance measures are being developed. Major national foundations are sponsoring access projects for children.

But where in all this are the experts, the pediatric dentists? Many of us are at the chair doing the work that policymakers can only talk about. A few are at their state dental associations pressing their state group to take Medicaid reform to the Statehouse. Some are at their pediatric dentistry society meetings strategizing change. Fewer still are working hand in hand with sympathetic legislators, state bureaucrats, and advocates doing the hard work of substantiating the problem, creating political will and garnering public attention. Sadly for children without regular dental care, most pediatric dentists seem to be talking only to each other about their grievances or ignoring the program altogether, rather than working to effect change. In the end, the biggest Medicaid problem of all may be pediatric dentists who tolerate the status quo, acquiesce to marginal programs, quietly quit, and go about their business providing excellent care only to those who can find their way through the front door. Yet change happens only when people who care organize and act. Medicaid reform is not only possible, it is almost

assured when children's dentists become children's advocates and when dentists' personal convictions are translated into political muscle.

There are things you can do in your state that will get the attention of policy makers who control public resources. Your role is to get the ball rolling and provide expertise. Others will do the "heavy lifting" once the dental issue becomes their own. Start locally by bringing together an effective child advocate, the PTA, a school nurse, a local health officer, a locally elected state legislator, a staffer from your Congressman's office, the president of the State's dental society, an influential pediatrician or emergency room doctor, the state dental director, leaders from local WIC and Head Start programs, visiting nurses, or a well respected local business person. Make the case that kids suffer needlessly because dental Medicaid isn't working for dentists, parents or children. Clarify that this is a community issue that they all have a stake in. Call upon your local core group to organize around Medicaid reform. Offer your services as a technical expert. Call for a state "summit". Challenge your Governor to show leadership and take action on this public health problem. Involve public officials who are responsible for solutions: the Medicaid Director, State Health Director, Maternal and Child Health Director, Primary Care Official and Rural Health Official. Help your local press bring the issue of children's pain and suffering to the public through feature articles, editorials, and letters to the editor. Create champions—local leaders who will promote the issue on behalf of children. Become a very squeaky wheel. Talk with colleagues in Indiana and Pennsylvania where such efforts have paid off. Ask the Academy for guidance. Use the HRSA-HCFA Oral Health Initiative's web page to download "state tools" including costing models, workforce models, geographic mapping information, and whitepapers. Put the issue of underserved children on the top of everyone's pile. It will get attention. Attention will bring solutions.

Let us look to our state-by-state successes in pushing insurance reform for general anesthesia coverage. Let us look to the successes of the mothers who brought us Mothers Against Drunk Driving and the advocates for vaccine, teen pregnancy prevention, lead and hearing programs. Let us emulate them. Let us take heart and take action so that neither disadvantaged children nor their dentists need suffer any longer.

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Letter to the Editor

Guidelines for Periodontal Therapy

I would like to sincerely congratulate the officials of the American Academy of Pediatric Dentistry for their fine work in editing and publishing the Reference Manual 1999-2000. Rightfully, the important goal of prevention of all oral diseases, including periodontal diseases has been clearly emphasized.

However, I am sorry to notice a lack of originality on the subject of periodontal health and diseases in children and adolescents. The American Academy of Pediatric Dentistry has repeatedly quoted the guidelines of the American Academy of Periodontology, which by nature focuses on adult diseases, therefore, not fully reflecting the special aspects of periodontal diseases in children and adolescents.

One must be impressed by the continuous and increasing number of manuscripts on the subject of periodontal diseases in children and adolescents in the scientific literature, mainly during the last few years. The need for prevention, early diagnosis and early treatment of periodontal diseases in children and adolescents, including those that involve mucogingival problems and destructive periodontal diseases, has been clearly emphasized by manuscripts that demonstrate the fact that the onset of destructive periodontal diseases may be in childhood. It is our basic responsibility to prevent, early diagnose and early treat every oral disease, including periodontal diseases, before complications take place and the quality of life of our patients is irreversibly damaged.

It is somewhat sad that a computerized search on manuscripts on periodontal diseases in children reveals that only a few of the manuscripts that have been published are in Pediatric Dentistry journals. Are we turning our head away from a problem which others have recognized?

The American Academy of Pediatric Dentistry can take the lead and start with the process of developing their own policy and guidelines for periodontal diseases in children and adolescents. For this purpose, at least specialists in Pediatric Dentistry, Periodontology and Orthodontics should blend their knowledge. Each specialist should provide his/her input on subjects such as behavior management, oral growth and development, caries prevalence and severity, periodontal diseases, the connection between systemic status and periodontal conditions and the relation between periodontal conditions, malocclusions and orthodontics.

This will not be an easy task but it is necessary for the future quality of life of our patients.

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