Financing Oral Health Care for Low-Income Adults Living with HIV/AIDS

Helene Bednarsh, RDH, MPH[a]
David A. Reznik, DDS[b,c]
Carol R. Tobias, MMHS[d]

The 2000 Surgeon General's report *Oral Health in America* documented disparities in access to oral health care, especially for vulnerable adults such as those with chronic medical conditions, and affirmed that "You cannot be healthy without oral health."[1] Inadequate access to oral health care has serious implications for both the systemic and oral health of people living with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (PLWHA). For this population, untreated oral disease can lead to conditions that have a detrimental impact on physical health and quality of life.[2]

The HIV Cost and Services Utilization Study (HCSUS), a national probability sample of adults living with HIV conducted in the 1990s, found that PLWHA were more than twice as likely to have unmet dental needs than unmet medical needs.[3] Although most of the peer-reviewed literature on unmet oral health needs for PLWHA stems from this study and, thus, is quite dated, there has been ongoing documentation of unmet need from the Health Resources and Services Administration, HIV planning councils/consortia, and consumer surveys among PLWHA.[4–9]

Studies have found that financial barriers—the lack of dental insurance or the inability to pay out-of-pocket for dental care—are leading causes of unmet need. Dental insurance is an important vehicle for financing oral health care, but the number of people without dental insurance (more than 108 million Americans) is 2.5 times greater than the number of people without medical insurance.[10] While dental coverage may improve access to care, this access may be mitigated by other financial barriers, such as deductibles, copayments, and annual maximum benefits, even for those who have insurance.[11]

This article provides background on the two key sources of coverage that finance oral health care for PLWHA: Medicaid and the Ryan White HIV/AIDS Program (hereafter, Ryan White Program).[12,13] We then present reasons that, especially in the context of health reform, policy makers need to address the

[a]Boston Public Health Commission, HIV/AIDS Services Division, HIV Dental Ombudsperson Program, Boston, MA

[b]Grady Health System, Infectious Disease Program, Atlanta, GA

[c]Emory University School of Medicine, Atlanta, GA

[d]Boston University School of Public Health, Health & Disability Working Group, Boston, MA

Address correspondence to: Helene Bednarsh, RDH, MPH, Boston Public Health Commission, HIV/AIDS Services Division, HIV Dental Ombudsperson Program, 1010 Massachusetts Ave., Boston, MA 02118; tel. 617-534-3737; fax 617-534-2819; e-mail <hbednarsh@bphc.org>.

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issue of sustainability of these sources of coverage if we are to ensure access to care and promote oral health for PLWHA.

ADULT MEDICAID DENTAL COVERAGE

Medicaid, the federal and state program that provides health-care benefits to low-income people and those living with disabilities, is a major source of health-care coverage, including oral health care, for PLWHA. Most people with HIV who qualify for Medicaid do so by meeting the program's income and disability standards. However, many PLWHA may not gain Medicaid coverage until their illness progresses to the point that they are determined to be eligible as a result of disability, even though national treatment guidelines recommend access to early treatment.[14] Presently, 68% of PLWHA have incomes below 100% of the federal poverty level (FPL), yet only 34% qualify for Medicaid.[15]

While federal regulations mandate Medicaid coverage for many adult services such as outpatient physician visits and hospital care, other services including oral health care are optional; for these services, coverage is determined by each state. In 2006, 10 states provided full dental coverage, 18 provided limited coverage, 16 covered only emergency dental services, and six did not offer adult dental coverage. A fiscal year (FY) 2010 survey of Medicaid programs reported a reduction in Medicaid adult dental benefits in 20 states, more than in any year in the past decade; 14 states planned to reduce benefits in FY 2012.[16] For example, the Massachusetts Medicaid (MassHealth) adult dental benefit was comprehensive until FY 2010, when coverage was limited to diagnostic procedures, preventive care such as cleanings, emergency visits, and extractions.[16] California's adult dental benefit (Denti-Cal) provided comprehensive care in the past, but presently limits coverage to dental emergencies only.[17] Access to oral health care may still be constrained, even in states where Medicaid covers adult dental care, because relatively few dentists participate, many people face geographic barriers to care, administrative requirements can be arduous, coverage is often limited, and Medicaid reimbursement is low compared with a dentist's usual fee.

Medicaid does have certain provisions that allow states to promote coverage for oral health care. For example, Section 1115 of the Social Security Act authorizes the executive branch of the federal government to permit states to waive the statutory and regulatory provisions of the Medicaid program, such as the disability eligibility requirement. To use Section 1115 waivers, however, states face several challenges, particularly the need to demonstrate budget neutrality to the Medicaid program.[18] This provision mandates that the costs of an expansion over a designated period of time, five years, would not exceed the costs to Medicaid in the absence of the expansion. Several states, including Massachusetts and Maine, have successfully applied for a Section 1115 waiver to expand eligibility and, thus, access to oral health care, if offered, to PLWHA.[19,20] Under new guidelines recently released by the Centers for Medicare & Medicaid Services, several additional states may consider this option.[18–20]

Medicaid eligibility for PLWHA will also be expanded under the Patient Protection and Affordable Care Act (ACA).[21] Starting in 2014, Medicaid eliminates the disability requirement for Medicaid eligibility for individuals with income below 133% of the FPL and immediately expands access to Medicaid. To date, California, Connecticut, the District of Columbia, Minnesota, New Jersey, and Washington have, to varying degrees, exercised this option under the provisions of the ACA.[16,17]

Although the maintenance-of-effort provision in the ACA bars states from placing new limits on Medicaid eligibility, and in anticipation of the 2014 change just described, many states have responded by reducing or eliminating optional benefits, including adult oral health care, to contain costs.[22] According to the executive director of the Kaiser Commission on Medicaid and the Uninsured, adult dental benefits are always vulnerable in hard times: "Dental benefits for children are not an option for state cuts. It's adult dental that is one of the first benefits to be cut."[23,24]

RYAN WHITE PROGRAM COVERAGE

The Ryan White Program is an important source of oral health-care financing for PLWHA and is designed to fill gaps in coverage from other sources. This program serves PLWHA who are uninsured, have insufficient health-care coverage, or lack financial resources to get the care they need. The Ryan White Program is not an entitlement program, but rather a discretionary budget item subject to annual congressional appropriations.[25]

The Ryan White Program was originally passed by the U.S. Senate on May 16, 1990, by a large margin, signaling exceptional bipartisan support since its inception.[26] Originally known as the Ryan White CARE Act, this piece of federal legislation was named in honor of Ryan White, a teenager from Indiana who had contracted HIV through a transfusion.[25] Today, the Ryan White Program is the largest federal program focused exclusively on HIV/AIDS care. Every year, the Ryan White Program reaches more than 500,000 uninsured and underinsured individuals who also may

not have the social and family support that is essential for coping with a devastating and stigmatized disease, such as HIV/AIDS.[27]

Currently, the Ryan White Program is implemented through the following parts:

- Part A: Grants to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas, which are disproportionately impacted by the HIV epidemic. Most Part A grants are administered by city or county health departments through subcontracts with other providers. Allocation of grant funds is prioritized by planning councils that include PLWHA.
- Part B: Grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants are generally administered by state health departments through subcontracts with other providers.
- Part C: Funding for comprehensive primary care in outpatient settings. These grants are administered by clinics, hospitals, federally qualified health centers (FQHCs), or health departments.
- Part D: Funding for family-centered care in outpatient or ambulatory settings for women, infants, children, and youth. These grants are also administered by clinics, hospitals, health departments, or social-service agencies.
- Part F: Funding for a variety of programs including the research-oriented Special Projects of National Significance program; AIDS Education and Training Centers; the Minority AIDS Initiative; and two unique oral health programs—the Dental Reimbursement Program (DRP) and the Community Based Dental Partnership Program (CBDPP).

The Ryan White Program currently mandates that 75% of the funds granted to Parts A, B, and C be directed to core medical services. Core medical services include oral health care as well as outpatient and ambulatory health services, AIDS Drug Assistance Program treatments, AIDS pharmaceutical assistance, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, mental health services, substance abuse outpatient care, medical case management including treatment adherence services, and support services.[13]

An important source of oral health care for PLWHA is the DRP in Part F, which reimburses dental education facilities (such as accredited dental schools, dental residency programs, and dental hygiene schools) a percentage of their uncompensated costs incurred when providing care to PLWHA. In FY 2010, Congress appropriated approximately $9.2 million to the DRP.[28] These funds were accessed by 56 dental education facilities to provide services to more than 35,000 individuals. Applicants received about 32% of their reported nonreimbursed costs incurred in providing care during the period July 1, 2008, through June 30, 2009.[28] The CBDPP in Part F increases access to oral health-care services for PLWHA by providing education and clinical training for dental care providers in community-based settings through partnerships with accredited dental education institutions and local community agencies. In FY 2010, $3.5 million was appropriated to 12 CBDPP grantees to provide care for more than 5,600 individuals.[28]

Across all parts of the Ryan White Program in FY 2008, a total of 86,446 unduplicated clients had 285,380 oral health visits. In FY 2008, $24,568,389 was allocated for oral health care in Part A (approximately 5.8% of the $420,377,373 allocated for core medical services) and $11,338,712 was allocated for oral health care in Part B (6.9% of the $164,849,452 allocated for core medical services).[29]

Oral health programs serving uninsured and underinsured PLWHA have been established through the various parts of the Ryan White Program. One such example is within the Boston Public Health Commission, which received Part A funding (then called Title I EMA) in 1991 and established the HIV Dental Ombudsperson Program to provide access to oral health care for PLWHA. The program is a public/private model based on a dental case-management system to enroll eligible clients and refer them to care. Providers are reimbursed at state-determined rates to provide comprehensive dental services. The program has been funded for 21 years and has enrolled 10,000 patients during that time. It currently serves about 2,000 unique clients every year with both Part A and Massachusetts Department of Public Health funding.[30]

The Michigan Dental Program, part of the Michigan Department of Communty Health, offers a second example of a model oral health program. Begun in 2002, the program has provided comprehensive oral health care to more than 2,000 HIV-positive individuals in Michigan. Ranging in age from 15 to 83 years, the dental program's clients have access to more than 200 providers statewide, including two dental schools and several FQHC dental clinics. The Michigan Dental Program is currently funded through Ryan White Parts B and D, as well as Part A through collaboration with the Detroit EMA.[31]

Taking into consideration the variability of Medicaid coverage, the lack of a Medicare dental benefit, and the number of uninsured and underinsured PLWHA in the U.S., the Ryan White Program funding is vital for continued access to oral health services for this vulnerable population.

SUSTAINING ORAL HEALTH FINANCING

The sustainability of oral health programs depends on securing the financial resources needed for these programs to remain viable. The RAND Corporation report on the HCSUS findings concluded that increasing access to oral health care for PLWHA could be accomplished by changes to dental coverage policies, especially the inclusion of adult dental services in all state Medicaid programs.[11] Thus, robust Medicaid coverage is one way to maintain sustainability of oral health care for PLWHA. As an entitlement program, Medicaid has the potential to be an essential underpinning of sustainability, even though the optional nature of dental coverage makes reliance on Medicaid as a safety net for adult PLWHA problematic. The recent economic downturn may severely limit most states' ability to expand and even maintain existing adult dental coverage through Medicaid. Programs in states with reduced or total elimination of Medicaid adult dental coverage will need to rely even more heavily on funding through the Ryan White Program to sustain their current levels of care.

The Ryan White Program provides significant funding for oral health care, but it is a discretionary part of the federal budget and not an entitlement. The current U.S. budget crisis has placed extraordinary pressure on discretionary spending. Although increased congressional appropriations are needed to expand the number of clients accessing oral health care through the Ryan White Program, such an increase may not be feasible in the present economic and political climate. There is some speculation as to what changes may occur in the next reauthorization of the Ryan White Program, which is scheduled for 2013. An important issue is the expectation that the ACA will expand basic Medicaid coverage in 2014 to individuals with incomes up to 133% of the FPL, regardless of disability status, as noted previously. Although the ACA may make many PLWHA Medicaid eligible, it does not include adult dental benefits in the newly expanded Medicaid program.[21] Thus, to maintain the oral health safety net for PLWHA, the Ryan White Program services must be reauthorized and emphasis must be placed on allocating resources for the provision of oral health care. Advocacy by PLWHA and other oral health champions in the local decision-making process is extremely important to ensure continued access to oral health care through the Ryan White Program.

CONCLUSIONS

Oral health care remains a top unmet need for PLWHA. Even with the most motivated oral health-care-seeking behavior, if PLWHA cannot access care due to the inability to pay, cannot find a provider, or cannot overcome barriers to care, these vulnerable individuals will not receive needed oral health care. For uninsured and underinsured PLWHA, limited financing of oral health care remains a significant barrier to care. The variation in Medicaid adult dental coverage among states alone creates oral health disparities based on a person's place of residence. Reauthorization of the Ryan White Program is vital for continued access for PLWHA and serves as a mechanism to address the aforementioned disparities.

A recent report from the American Dental Association, "Breaking Down Barriers to Oral Health for All Americans," emphasized the importance of all stakeholders investing in and maintaining the safety net for care. It notes that funding oral health care should be viewed as an ongoing investment to reduce the burden of disease and improve health.[32] Financing mechanisms must be more stable for vulnerable populations to achieve and maintain oral health.

Solving the financial barriers to oral health care that PLWHA face could serve as a model to address similar barriers faced by other vulnerable populations. All low-income and medically compromised patients would be better served if adult dental Medicaid coverage was a mandatory, not optional, service, and if the Medicaid expansion slated for 2014 in the ACA were to include adult oral health-care coverage. The Ryan White Program is the largest federal program focused exclusively on HIV/AIDS care; therefore, the continuation and expansion in the 2013 reauthorization is critical to maintaining not only the oral health-care safety net for PLWHA, but also all other medically necessary services not addressed in the ACA. The services offered via the Ryan White Program should serve as an archetype for future programs targeted toward the larger at-risk community.

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