Consortium on Law and Values in Health, Environment & the Life Sciences

Student Proposal Cover Page

Applicant Information

Applicant Name: **Geeta Naidu** Date: **03/23/09**

Project Title: **Increasing Access to Oral Health Care: Enforcing Medicaid and CHIP Dental Provisions**

Department: Law/ Public Health Administration and Policy College: Law School/ School of Public Health

Home address: **3022 Dupont Ave South** City & State: **Minneapolis, MN** Zip: 55408

Faculty advisor name: Lynn Blewett Email: blewe001@umn.edu ☐ Not applicable

Dept. Head's name: Beth Virnig Dept. Head's email: virni001@umn.edu

Dean's name: John R. Finnegan, Dean's email: finne001@umn.edu

How did you hear about this funding opportunity? Joint Degree Program Newsletter

Funding

Amount of funding requested: **$5000**

Funding justification: [a clear statement of what you will use the funds for without going into budget details]

I am requesting salary funds to support the research and writing of my Master's Project.

Approvals

Check all appropriate approvals required for your proposal. Approvals must be obtained prior to receipt of funding. If you have applied for approval but have not yet received it, indicate that below.

☐ IRB Date submitted: N/A Number:

☐ IACUC Date submitted: N/A Number:

☐ Other Explain:

For Use by the Consortium Office

☐ The proposal is 1000 words or less excluding budget, biographies, references and citations.

☐ The proposal includes a work plan with a specific timeline using months or quarters to identify work to be done and completion dates.

☐ The proposal includes a 1-2 paragraph biography of the applicant and all co-investigators.

☐ The budget form is complete including the funds sought for this project, other pending applications for this project, and the amount/source of matching or other funds.

☐ The applicant's faculty advisor is copied on the application email. Professional students w/o advisors check NA.

☐ All necessary approvals are pending or received.

Increasing Access to Oral Health Care: Enforcing Medicaid and CHIP Dental Provisions

Dental disease is the most common chronic disease among children.[1] Recent national surveys suggest the prevalence of dental disease among children is increasing – from 24% during 1988-1994 to 28% during 1999-2004.[2] Prevalence is higher among minority and low-income children who also experience greater destruction of teeth when affected and a higher frequency of dental pain.

Dental care is the most common unmet health need among children.[3] Untreated dental disease may lead to poor nutrition due to difficulty eating, missed school days due to pain, trouble communicating and interacting with others, and delayed ability to speak. Dental disease is prevalent among low income children despite the fact that Medicaid and the Children's Health Insurance Program (CHIP) are available to most poor and near poor children. Medicaid and the CHIP are state administered public insurance programs which are partly financed by the federal government. In order to receive federal funds, states must comply with a number of provisions designed to ensure a basic benefit set, quality health care, and access to health services.

States are required to provide the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service, a preventative program targeting Medicaid enrolled children through age 21. EPSDT services include dental screening and treatment necessary to correct conditions or illnesses discovered through screening.[4] To support the implementation of the EPSDT program, states must assure the availability and accessibility of services, and assist parents to effectively use EPSDT resources.

Until recently, states were not required to provide dental coverage to CHIP enrollees. The 2009 reauthorization of CHIP included a number of provisions designed to improve the oral health of enrollees including, a dental coverage guarantee, mandatory performance reporting and mandatory information requirements.

Despite the availability of dental screening and care through EPSDT, oral health among Medicaid enrolled children is worsening. According to recent evaluation by the Government Accountability Office, 62% of Medicaid children had dental disease, 33% had untreated dental disease and 11% had severe oral health problems or untreated tooth decay in three or more teeth.[5] In 2004-2005, 63% of children had not received dental care, 13% reported that they never saw a dentist and 4% tried but were unable to access dental care within the last year.[6]

The Department of Health and Human Services establishes utilization and participation goals and holds states accountable for Medicaid obligations by withholding funding upon a showing of noncompliance. This method of enforcement is contrary to the underlying program goals and thus is rarely employed. Individuals in several states have responded to poor dental access and enforcement by suing state government officials under 42 U.S.C. §1983. §1983 is a "civil rights measure that provides a federal cause of action against state officials who violate individual

rights secured by federal statutes." [7] Medicaid beneficiaries have employed §1983 to force states to comply with EPSDT requirements. This legal tool will likely be employed by CHIP beneficiaries to enforce the new CHIP dental provisions.

Medicaid and CHIP have not improved the oral health of poor and near poor children. Thousands of insured children are unable to obtain necessary care.[8] My master's project will examine ways of increasing access to dental care among Medicaid enrolled children. The project will consist of four parts:

1.) Identify innovative state and community initiated interventions that target the oral health of this population and which could be implemented on a broader scale.
2.) Discuss institutional enforcement mechanisms to ensure state compliance with EPSDT and CHIP dental requirements and encourage states to make dental care a high priority.
3.) Research the application of §1983 lawsuits to the new CHIP dental provisions and examine legal tools that individuals may use to force state compliance with EPSDT requirements.[9]
4.) Finally, I will examine the role of the public health agencies, state Medicaid agencies, CMS and dental professionals in and their legal and ethical responsibility for providing for children's oral health.

This project examines the interaction between community and policy solutions, legal requirements and professional responsibility in delivery of dental care to Medicaid children. In addition to a literature review of health policy, epidemiological studies and case law, I plan to conduct key informant interviews with state oral health officials and dental professionals. Research for this project requires me to study the intersection of administrative law, civil rights, health care service delivery, health finance and public health policy. Conclusions from this research will inform state health policy officials and the dental community through publication in journals and potentially, in professional newsletters. Throughout this process I will be advised by Dr. Lynn Blewett, professor at the School of Public Health and director of the State Health Access Data Assistance Center. Peter Scal, MD/MPH, a professor of pediatrics at the medical school who has researched pediatric oral health, will provide additional support and expertise.

Importance of the Project

Although there is agreement that dental care for Medicaid children is unsatisfactory, it is still an overlooked topic in health policy. Oral health is not comprehensively addressed in public health policy journals. The few articles that specifically address oral health policy in this population focus on justifying the importance of oral health without offering sustainable, broadly applicable solutions to improve the oral health of children in Medicaid. Other articles examine a single local intervention without placing it in context of overall Medicaid policy or health policy. Writing on local interventions apart from the broader context of oral health policy contributes to information gaps and a fragmented oral health policy. This project will develop a framework for a more cohesive oral health policy by comprehensively addressing oral health solutions, requirements and responsibilities. My project will bridge enforcement of the EPSDT program with methods building state capacity to meet the dental requirements of Medicaid.

Work Plan

Fall Semester: Preliminary research, key informant interviews and literature review.
Spring Semester: Work with faculty advisor to publish.
February 2010: Draft of Master's Project.
April 2010: Finalize and Present Master's Project.

Biography

I first became interested in oral health while interning at Children's Dental Services (CDS), a non profit dental clinic in Northeast Minneapolis. After college I spent a summer working as a health assistant for a migrant Head Start program in southern Minnesota, where I coordinated the dental care of insured children. I made appointments and transported children from school to the dental office, at times driving hours to obtain necessary care. It was frustrating that dentists would refuse to see even insured children and humbling to understand that many of the children only saw a dentist because they were enrolled in Head Start.

After the summer, I joined CDS full-time. As a Public Health Outreach Worker, I managed the care of children whose dentition was in such poor condition they required general anesthesia to be treated. I gained experience with the operation of public and private insurance, disparities in oral health care, dental workforce issues and dental financing. Importantly, I saw first hand the impact of dental disease on the overall health of a child, from pain and poor nutrition, to a low confidence and difficulty communicating. The painful physical and mental effects of a lack of access and preventative care were everyday occurrences at CDS. I applied to the University of Minnesota's JD/MPH program with the goal of improving oral health for children. Currently, I am a student researcher at the Minnesota Department of Human Services where I work on several issues related to oral health including dental services delivery models and the implementation of the oral health practitioner, a mid-level dental provider. This summer I will move into oversight of federal programs as a legal intern for the Department of Health and Human Services, Office of the Inspector General. I hope to continue working with state and federal government to improve population health.

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[1] Ritter, Dianne. "Delivering Preventative Oral Health Services in Pediatric Primary Care: A Case Study.." *Health Affairs*. November/December 2008.

[2] Ritter, Dianne. "Delivering Preventative Oral Health Services in Pediatric Primary Care: A Case Study.." *Health Affairs*. November/December 2008.

[3] Fisher-Owens, Susan A. et. al. "Giving Policy Some Teeth: Routes to Reducing Disparities In Oral Health." *Health Affairs*. 27(2) 2008.

[4] http://www.ssa.gov/OP_Home/ssact/title19/1905.htm

[5] Statement of Alicia Puente Cackley. "The Extent of Dental Disease in Children Has Not Decreased." Government Accountability Office. September 23, 2008. Publication No. GAO-08-1176T.

[6] Statement of Alicia Puente Cackley. "The Extent of Dental Disease in Children Has Not Decreased." Government Accountability Office. September 23, 2008. Publication No. GAO-08-1176T.

[7] Donenberg, Jon. Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements. Yale Law Jouranl. May 2008.

[8] Statement of Alicia Puente Cackley. "The Extent of Dental Disease in Children Has Not Decreased." Government Accountability Office. September 23, 2008. Publication No. GAO-08-1176T.

[9] *Wilder v. Virginia Hospital Ass'n.* 496 U.S. 498 (1990).

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Budget for Student Proposals

Project Title:

Instructions: add rows for multiple personnel.		**Requested funding**	**Matching/other funding**	
Category	**Description & justification**	**Amount**	**Amount**	**Source**
Personnel **Hourly wage is based on 2008-2009 pay rates for a graduate assistanship in the School of Public Health. Hours worked is based on 10 hours per week for the academic year.**	Salary = __300_hrs x __16.75___ hrly wage	$5,000		
	Fringe rate			
	What work will this person do?			
	Subtotal			
Speaker Honoraria	**___ speakers x $ _____ honorarium**			
Supplies & Services	List items and explain use.			
Equipment *Equipment costs are allowable only if the justification clearly shows that the equipment is necessary for the project. Include explanation of what will happen to equipment at completion of project.*	Identify and explain use.			
Travel *Travel costs must include a description of the purpose of the travel, start and stop dates of travel, transportation costs, housing costs, and allowable per diem (use University rates found at http:// travel/umn.edu).*	Explain.			
	Subtotal research supplies, equipment, travel, other			
TOTAL BUDGET		$5,000		