MATERNAL AND CHILD HEALTH ACCESS

May 2014

Educate and Advocate: Oral Health During Pregnancy for Low-Income Women in California

"I've been doing research on the internet and I came across mchaccess.org. I'm about 4 ½ months pregnant and I'm in severe pain in my lower jaw. I know there's something going on in my molars. And I've noticed that you're . . . an advocacy group to help pregnant women with their dental issues and I was just seeing if you could help me or guide me where I could get treated or see a dentist. I've been calling around [to] a few dentists and they don't want to see me – they say that Medi-Cal doesn't cover…"

MCHA client, early January, 2014 -– link to her voicemail on our website

Introduction

In 2009, Maternal and Child Health Access (MCHA) partnered with the Community Clinic Association of Los Angeles County (CCALAC) to create the Oral Health Advocacy for Pregnant Women and Children "Project". Funded by First 5 LA's Community Opportunities Fund, the project focused on increasing access to dental care for pregnant women and for children up to five years old. The project's main goals were to reduce or eliminate policy and administrative barriers to oral health care for these two populations, help integrate prenatal and oral health services in community clinics and other practices, and ensure dissemination and implementation of national evidence-based guidelines for oral health care for pregnant women. An important aspect of the project was the technical assistance MCHA provided to low-income pregnant women and providers with questions or a coverage issue. This activity gave us the platform for our policy advocacy work and connected us with the real issues pregnant women face.

Importance and Need

Most low-income pregnant women do not receive oral health care in California, even when they are in pain.[1] Yet dental services during pregnancy are both necessary and safe, according to the American College of Obstetricians-Gynecologists and the American Dental Association.[2]

Research emerging nationally in the mid-1990s showed that dental disease is associated with premature births and low birthweight births,[3] which, combined, are the second leading cause of infant death in the United States.[4] Preterm deliveries also put the mother's health at risk. Although causation has not been established, some experts note that very few resources have as yet been allocated for research on oral health during pregnancy. Moreover, there are definite relationships between poor oral health and cardiovascular disease, diabetes, and respiratory diseases, each of which increases the risk of complications in pregnant women. Insurance companies have found that providing dental coverage for pregnant enrollees has lowered overall costs for women's medical coverage while reducing hospitalizations and improving overall health.[5]

Adding to the need for care, early childhood caries are more likely in the children of mothers with their own high levels of oral bacteria and poor oral health; dental caries can be passed on to newborns and children through bacteria in the mother's saliva.[6]

The New York State Department of Health released practice guidelines for pregnancy and early childhood in 2006. In 2010, California released *Oral Health During Pregnancy & Early Childhood: Evidence-Based Guidelines for Health Professionals*, an effort of the California Dental Association and the American College of Obstetrics and Gynecologists, District IX. The guidelines provide information, dispel myths and educate and provide guidance on the safety and importance of oral health during pregnancy and for young children for all providers who interact with these groups, from prenatal professionals to community-based program providers. The Project relied on these guidelines and specifically the consensus statement, "*Dental treatment including dental radiographs can be undertaken during pregnancy with no additional fetal or maternal risk when compared to the risk of not providing care*",[7] to educate community providers and increase access to care.

Despite resources and recommendations available, pregnant women and providers who treat them continue to be unaware of or unable to use two essential pieces of information: 1) that Medi-Cal benefits include dental services and 2) that pregnant women can safely access oral health services during any trimester and it is in the interest of the woman's health to do so.

Changing Coverage

Medi-Cal for pregnant women is either "full scope" – comprehensive coverage – or "pregnancy only". Pregnancy-only Medi-Cal includes prenatal and delivery-related services, including family planning. Dental coverage for women with pregnancy-only Medi-Cal is relatively new and has changed over time, leading to confusion among providers as well as consumers and the general public about which procedures are covered.

Adult Medi-Cal recipients had full dental coverage for over 40 years, before the state eliminated non-emergency adult dental benefits in 2009. However, women with pregnancy-only Medi-Cal had no dental coverage at all until 2001, when policy advocates, including MCHA, succeeded in having the state adopt at least several basic preventive services for most women with pregnancy-only Medi-Cal. The services included exams, cleanings, and gum treatment.

Policy advocacy continued so that, in 2005, coverage was expanded to all pregnant women on Medi-Cal. When Medi-Cal dropped non-emergency dental benefits for most adults in 2009, basic preventive services were retained for pregnant women.

Continued policy advocacy has been necessary to have Medi-Cal adopt the broadest possible list of preventive dental benefits for pregnant women. MCHA pressed for inclusion of all medically necessary dental services, under the federal rule that "pregnancy-related" care means not only "routine" prenatal and labor and delivery services, but also services for "other conditions [than pregnancy] that might complicate the pregnancy."[8] In an important victory for consumers, this rule was eventually adopted. Burdensome administrative procedures, however, have made it nearly impossible to access broader benefits. For example, dental providers must first have a claim for broader services which are rejected, and then prove the services were necessary to treat or avoid a condition that might complicate the pregnancy. Efforts to improve this process are continuing.

In the meantime, MCHA's policy advocacy has resulted in the inclusion of women with pregnancy-only Medi-Cal coverage among the adults for whom dental benefits are being partially restored starting May 1, 2014. The benefits being restored for adults include fillings, full sets of dentures (but not partials), and anterior root canals[9]; these services will be added to the exams, cleanings, and gum treatment already being provided to women with pregnancy-only Medi-Cal. It is important to underscore that gum treatment is an existing benefit for pregnant women, though it is unfortunately not one of the benefits restored for other adults.

Issues for Pregnant Women

Medi-Cal beneficiaries in general, and perhaps particularly pregnant women, are often unaware that preventive dental benefits are a covered benefit. The information is not identified on the Medi-Cal card nor is the information or advice to visit a dental provider passed on by the prenatal provider or by other clinic staff. Worse, both prenatal and dental providers may misinform women that they have no dental benefits at all.

As noted, there are too few dental providers who will treat pregnant women. Identifying providers takes time, requiring calls to each provider individually.

Pregnant women may be fearful of visiting a dental provider, due to safety concerns, in particular radiation emitted from x-rays.

If they are successfully seen, they may be handed a treatment plan. Often they cannot afford to pay for restorative services that Medi-Cal does not cover, such as a posterior root canal.

Provider Issues

Provider issues include confusion about whether and to what extent women with pregnancy-only Medi-Cal coverage have any dental coverage at all. Confusion intensified with the elimination of most adult dental benefits in 2009, affecting pregnant women's access to preventive benefits, since providers knew only that "adult dental benefits were cut" and not that some populations – including all pregnant women and teens - still had them.

Difficulties in billing and low reimbursement rates compound the confusion about coverage and result in too few dentists accepting Medi-Cal-- only one in four, according to one survey.[10] No one has surveyed or tracks how many dentist see pregnant women.

Finally, dentists generally are not in agreement about providing dental care during pregnancy. According to a statewide study in California, dental education provides little exposure to pregnant women.[11] Many dentists who accept Medi-Cal simply tell women to wait until after their baby is born, sometimes treating just for pain and sometimes not.

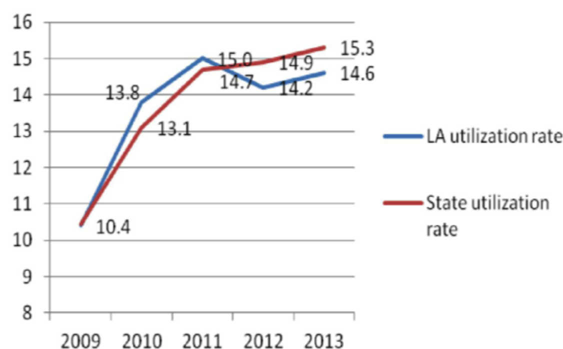
This attitude could change in the foreseeable future, however, given the numbers of older dentists who are nearing retirement age in 2012 and the fact that among newly licensed dentists in California in 2012, 46% were female.[12] Pregnant women should be referred to dentists "as would be the practice with referrals to any medical specialist".[13] Although it is changing slowly, educational challenges among dentists and at dental schools remain.

MCHA and CCALAC Partnership, 2009-2014

The Oral Health Advocacy Project offered a key opportunity to educate broadly in Los Angeles County about providing oral health services to pregnant women with Medi-Cal during a time period when most adults had no dental coverage. MCHA developed and broadly distributed oral health posters and other educational materials among prenatal and dental providers as well as consumers. MCHA and CCALAC identified several local best practice models and shared them with providers, and provided oral health education and referrals to dental services to hundreds of women. The project culminated in a conference attended by over 100 providers, clinic representatives, home visitors and social service staff and, included the Director of Medi-Cal's Dental Division and other top state staff. Attendees shared information and best practices, identified recommendations, and developed related action plans that were later sent to them as a reminder of their commitments.

In addition, MCHA tracked utilization of oral health services accessed by pregnant women with Medi-Cal to see if our efforts were effective. This was a difficult task. A pregnant woman may receive services under one or two of approximately one hundred "aid codes" which categorize the benefits received and continuity of the benefit after pregnancy. Several different methods were tested to estimate pregnant women's dental utilization, the first time an analysis of this type has been conducted.

The most targeted method tracked utilization in all "pregnancy-only" aid codes, which is by its nature an undercount since some women are in full benefit aid codes. These data show the percentage of pregnant women ages 21-49 who received both a pregnancy-related medical service and a pregnancy-related dental service over the course of one calendar year. These data showed significant improvement in the percentage of pregnant women receiving dental services, although the actual percentage remains low. In Los Angeles, the utilization rate improved from 10.4 percent to 14.6 percent from 2009 to 2013. It should be noted that the 2013 rate may be an undercount since there is a lag time of six months or more in receiving all claims.



Policy Recommendations Going Forward

The policy recommendations are a direct result of the lessons learned from the project. Despite the necessity and the satisfaction of assisting individual women to access dental benefits to which they have a right, policy reform is needed to ensure progress is not achieved one woman at a time and to reach all women, not just those connected to a community-based organization. The following are the principal recommendations to ensure pregnant women get the dental care they need, stemming from our groundbreaking conference in February of this year and from the over 10 years total of this project:

1. Medi-Cal's adult dental benefits should be fully restored, and women with pregnancy-only Medi-Cal must be included in the restoration.

2. Simplify the ability for pregnant women to access dental procedures not on the state's list of benefits. Until adult dental benefits are fully restored, pregnant women are entitled to all medically necessary dental services, under the federal test for services to treat "conditions that might complicate pregnancy."

3. The Medi-Cal provider claim form should be modified to better capture information about pregnant beneficiaries seeking oral health services, and the state should regularly report such utilization data to the public. This will assist in providing policymakers and advocates with reliable data to effectively monitor problems and chart progress.

4. Medical and dental school curricula should be modernized to incorporate the latest research and standards on oral health services during pregnancy as well as best practice models for referrals.

Policy Recommendations Going Forward (cont.)

5. Reimbursement rates for Medi-Cal dental providers should be increased and billing procedures made simpler, with dedicated state staff to assist with providers treating pregnant women.

6. Provider education about oral health during pregnancy should be ongoing, e.g.,, Medi-Cal Dental Bulletins should have a dedicated section on pregnant women, with the same information provided in OB-GYN, Comprehensive Perinatal Services Program and Family Practice provider bulletins.

7. The State Denti-Cal website should identify providers willing to treat pregnant women.

8. A dental identifier should be added to the Medi-Cal card and "stuffers" sent to beneficiaries explaining the existence of and importance of oral health care for pregnant women.

Conclusion

Despite significant progress in recent years on coverage and access to dental health services for low-income pregnant women with Medi-Cal, much more needs to be done. The concept of integrating dental services with prenatal care is fairly new and will continue to require engagement, education, policy advocacy, and reform. Likewise, full dental benefits for all low-income people must become a reality to truly meet the needs of pregnant women.

Acknowledgements

Without the support of our funders, First 5 LA., and our prior funding from UniHealth Foundation and Catholic Healthcare West, this policy advocacy project would not have been possible. We are deeply appreciative of the opportunity to delve into this issue and to become a resource to the community, other organizations and policymakers.

Contact Information

1111 West 6th Street, Fourth Floor
Los Angeles, CA 90017-1800
(213) 749-4261
www.mchaccess.org ♦ info@mchaccess.org

Citations

[1] Marchi, K. et al, Most Pregnant Women in California Do Not Receive Dental Care: Findings from a Population-Based Study. Public Health Reports, November-December 2010, Vol. 125.

[2] ACOG Committee on Health Care for Underserved Women. (August 2013) Opinion No. 569.

[3] Offenbacher, S. et al., "Periodontal infection as a possible risk factor for preterm low birth weight," *Journal of Periodontology* 67 (1996); *see also,* Bobetsis Y, Barros S, Offenbacher S, Exploring the relationship between periodontal disease and pregnancy complications. *The Journal of the American Dental Association,* Vol. 137 (October 2006): no. suppl 2 7S- 13S.

[4] Howson C. et al., March of Dimes White Paper On Preterm Birth. March of Dimes Foundation, 2009.

[5] See*, e.g.,* United Concordia Oral Health Study. https://www.unitedconcordia.com/dental-insurance/dental/conditions/ucwellness-oral-health-study/results-ucwellness-oral-health-study/ Accessed 4-1-14.

[6] Weintraub, J.A. et al., Mothers' Caries Increase Odds of Children's Caries, *Journal of Dental Research*, Vol. 89 (September 2010): no. 9 954-958.

[7] California Dental Association, Oral Health During Pregnancy & Early Childhood: Evidence-Based Guidelines for Health Professionals February, 2010.

[8] 42 C.F.R. § 440.210 (a) (2).

[9] Denti-Cal Bulletin, Vol. 29, No.13 (August, 2013).

[10] Barbara Aved Associates: Without Change it's the Same Old Drill, October, 2012 at http://www.barbaraavedassociates.com/samples/denti-cal-final-report-nov-2-2012.pdf

[11] P. Glassman et al., Oral Health for People with Special Needs: Consensus Statement on Implications and Recommendations for the Dental Profession, *California Dental Association Journal* 33 (August 2005): 619-623.

[12] Pourat, N. and Moonkyung, K.C., Trends in the Supply of Dentists in California, *UCLA Center for Health Policy Research*, March, 2014.

[13] ACOG Committee on Health Care for Underserved Women. (August 2013) Opinion No. 569.