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SPECIAL INVESTIGATIONS DIVISION
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HEAD START HELPS LOW-INCOME CHILDREN RECEIVE NECESSARY DENTAL CARE

CURRENT PROPOSALS IN CONGRESS JEOPARDIZE PROGRESS

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EXECUTIVE SUMMARY

Difficulties in obtaining dental care have left millions of low-income children with untreated dental problems. The failure to provide appropriate dental care can lead to trouble eating, difficulties concentrating in school, and serious infections of the face, head, and neck.

Rep. Henry A. Waxman requested an investigation of one aspect of this crisis in access to dental services: the experience of young children in the Head Start learning program. Approximately one in five poor children under the age of five is enrolled in Head Start.

This report, which is based upon a nationwide survey of over 2,000 Head Start program directors conducted in 2002, finds that Head Start children have better access to care than other poor children, although substantial problems in access to dental care remain. The report also finds that proposed changes to the Head Start program would put this progress at risk. The report finds:

- **Enrollment in Head Start provides improved access to preventative dental care.** Children in Head Start are approximately three times more likely to receive dental screenings and preventative dental care than other low-income children.

- **Enrollment in Head Start provides improved treatment for dental problems.** Children in Head Start are approximately two times more likely to receive treatment for identified dental problems (such as cavities or gum disease) than other low-income children.

- **Despite Head Start's benefits, some children in Head Start do not have access to basic preventative dental care or dental treatment.** One in four children in Head Start (26%) do not have access to a source of "continuous accessible dental care," and almost half (45%) have not received basic preventative dental care. Problems such as inadequate Medicaid reimbursement, gaps in the dental health workforce, and inadequate services in community health centers are all contributing to the difficulty of obtaining necessary dental care for Head Start and other low-income children.

- **Bush Administration proposals to "block grant" the Head Start program place the program's successes at risk.** The Bush Administration has proposed replacing the Head Start program in some states with a "block grant." Such a change would eliminate the requirement that children in Head Start receive dental care.

INTRODUCTION

In a landmark 2000 report *Oral Health in America*, Surgeon General Dr. David Satcher described the impacts of untreated dental problems in children. In mild cases, mouth pain from untreated cavities may interrupt sleep at night and interfere with concentration in school. In more severe cases, dental problems can lead to trouble eating, and oral infections can require hospitalization. The consequences can be devastating. According to the Surgeon General's report, "If untreated, [dental cavities] can lead to abscess, destruction of bone, and spread of the infection via the bloodstream."[1]

Children in low-income families have more difficulty obtaining access to dental care than other children. The Surgeon General found that twice as many poor children as nonpoor children have untreated cavities.[2] Similarly, the U.S. General Accounting Office found in 2000 that poor children are twelve times more likely than higher-income children to miss school and other activities because of dental problems.[3]

At the request of Rep. Henry A. Waxman, the Special Investigations Division of the minority staff of the Government Reform Committee investigated one aspect of the access of low-income children to dental services: the experience of young children in the Head Start program.

Approximately one in five children in poverty under the age of five is enrolled in Head Start.[4] While 70% of these children have dental insurance through the Medicaid program, significant additional assistance is provided to help them obtain dental care. According to the program's rules, Head Start staff are directed to find dental services for enrolled children, even if this means locating dentists, making appointments, providing transportation, and even paying for services.[5] In

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1 U.S. Surgeon General, *Oral Health in America* (2000).

2 Clemencia M. Vargas, James J. Crall, and Donald A. Schneider, *Sociodemographic Distribution of Pediatric Dental Caries: NHANES III, 1988—1994*, Journal of the American Dental Association, 1229—1238 (Sept. 1998).

3 General Accounting Office, *Dental Disease Is a Chronic Problem among Low-Income Populations* (Apr. 2000).

4 U.S. Census Bureau, *Estimated Number and Percent People under Age 5 in Poverty* (1999).

5 Head Start centers must follow performance standards that include assuring appropriate dental care frequency, appropriate delivery of service, and appropriate follow-up. Programs must also assure that children found to require dental treatment on screening receive these services. *See* Head Start Performance Standards 1304.20(a)(1).

recent years, Head Start has partnered with the Health Resources and Service Administration and other government agencies to improve dental access.[6] Persistent difficulties obtaining treatment experienced by children in Head Start may reflect fundamental shortcomings in federal and state dental assistance programs and shortages in the dental workforce.

METHODOLOGY

In order to estimate the extent to which the Head Start program provides assistance to poor children in meeting dental needs, the Special Investigations Division obtained and analyzed the Head Start "Program Information Report" database. Every year, each Head Start program must fill out a detailed survey on the characteristics of the program and the children within it. This survey includes detailed questions on enrollment, attendance, staffing levels, demographics of the children in the program, and the medical and dental conditions of children in the Head Start program.

This survey includes several questions on dental care received and needed by children in the program. Specifically, the survey asks:

1. The number of children in the program who have received a professional dental examination;
2. Of those children examined, the number who received preventive care;
3. Of those children examined, the number of children diagnosed as needing dental treatment, in addition to routine cleaning; and
4. Of those children who needed dental treatment, the number who have received treatment.

In a health addendum added for the 2002 survey, the Program Information Report also asks whether children have an "ongoing source of continuous, accessible dental care."

After completion, survey forms are sent to the Head Start central office and compiled into the Program Information Report database. The Special Investigations Division obtained this database, which contains detailed records from approximately 2,000 Head Start programs with approximately 850,000 children in 50 states. This database, which contains data for 98% of Head Start programs at the time of the analysis, was then used to estimate dental needs for children in the Head Start program. The database was obtained for all years from

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[6] C. Jones et al., *Creating Partnerships for Improving Oral Health of Low-Income Children*, Journal of Public Health Dentistry, 193-196 (2000).

1998 to 2002, allowing an analysis of trends in the program. Only those Head Start programs serving children ages 3 to 5 were included in the study.

In addition to the estimates of the number of children who are in need of dental care, the Head Start database also contains descriptive comments from the Head Start staff on the status of dental care received by children in the Head Start program. These comments were excerpted to provide an anecdotal description of dental access conditions in the Head Start program.

The Special Investigations Division also consulted with oral health experts, including the Children's Dental Health Project, and reviewed available data to describe extent to which the Head Start program has provided assistance to poor children in obtaining dental care, and to understand the underlying causes of persistent access problems.

FINDINGS

The Benefits of Head Start

This analysis finds that children in the Head Start program are significantly more likely to obtain needed dental care than other poor children.

Head Start program directors reported that almost 90% of Head Start children had a dental screening in the last year and about 55% received preventive care. By comparison, only 27% of children aged three to five in Medicaid had any dental visit and less than 20% received preventive care in 1999, the last year for which data are available.[7] These data indicate that children in Head Start are over three times as likely to receive preventative dental care as other children in the Medicaid program.

When problems are identified, children enrolled in Head Start also appear to have better access to needed dental treatment than poor children who are not in the program. In both groups, approximately 30% of children who were examined had dental problems.[8] However, 76% of the children in Head Start who needed treatment received at least one treatment visit. In contrast, only an estimated 40%

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[7] Minority staff analysis of Center for Medicare and Medicaid Services (CMS) Form 416 reports for 1999 for available states.

[8] *Clemencia M. Vargas et al.*, *supra* note 2.

of the children in the Medicaid program with equivalent need for care received any treatment services.[9]

Despite Head Start's Benefits, Children in the Program Continue to Have Difficulties Obtaining Dental Care

Although the Head Start program provides significant assistance to poor children who are in need of dental care, systemic problems still prevent many children in the program from receiving adequate dental care.

Data from the Head Start program indicates that many children in the program either do not have access to dental care or are not receiving basic preventative services. More than one in four children in the Head Start program (26%) do not have access to a source of "continuous accessible dental care." And even children who do have access to care do not always receive it. As a result, over 45% of children aged 3-5 in the Head Start program have not received basic preventative dental care, such as fluoride applications or cleaning.

According to data collected by Head Start program directors, almost 90% of Head Start children obtained a dental screening in the last year. In the year 2002, almost 30% of these children, an estimated 211,000 children in total, were found upon screening to require dental treatment. In 24% of these cases, however, the children did not receive any treatment.

The data reported by Head Start program officials indicate that children in need of care are twice as likely to go without needed dental care as they are to go without needed medical care. Among children who needed medical treatment, 11% did not receive the care that they needed. This is less than half the prevalence of those not receiving needed dental treatment. This finding indicates that access to dental care is lagging behind access to medical care, even in a population where significant assistance is provided to help meet health care needs.

Several Factors Contribute to Problems in Dental Access for Head Start Children

In narrative answers submitted with their surveys, Head Start program directors from around the country complained about difficulty in accessing dental services.

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[9] A minority staff analysis of CMS Form 416 Reports found that 11.8% of children ages three to five obtained dental treatment services in 1999. Since an estimated 29.7% of children in this group have dental decay, this corresponds to approximately 40% of the estimated children with decay obtaining treatment services.

Common concerns among the Head Start program directors were the lack of dental providers and the resulting lack of access to care.

For example, one director wrote: "Dentals are very difficult for our families. Because of extremely poor reimbursement rates, few dentists will accept Medicaid or [SCHIP] . . . . This appears to be one of the greatest challenges facing our families."

Another director wrote: "Our community continues to face a dilemma in regard to dental health services. There is no dentist accepting new patients of preschool age who are covered by Medicaid. Our local dental clinic has provided on-site dental clinics for us this year. They have a waiting list at their clinic. Many of our children who still need dental examinations and work to be done are on their waiting list."

Another director reported: "Because the largest Medicaid Managed Care Provider in the county ceased operation in December 1999, all families who depended on them for medical and dental care, were required to find new providers. This caused an interruption in the continuity of dental care — children who had an initial dental exam and were diagnosed as need[ing] treatment, were unable to begin or complete treatment with their original provider, or receive dental prophylaxis. Families find that some dental providers who accepted Medicaid have long waiting lists (4 to 6 months) — many have made appointments, but the children may no longer be attending Head Start."

Another Head Start program director wrote: "The need for early dental care continues to be a problem. . . . At one point during the year . . . one of our primary dental providers, the Children's Hospital Dental clinic, had a six (6) month waiting list for a Saturday appointment."

Through reviews of national reports and through interviews with dental policy experts, three key systemic factors that contribute to problems in access to dental care for Head Start children were identified.

Medicaid Fails To Ensure Adequate Dentist Participation

In 2000, GAO found that in 23 of 39 state Medicaid programs surveyed, fewer than half of the state's dentists saw any Medicaid patients in the previous year. Not a single state was able to report that half of the state's dentists saw 100 Medicaid patients or more in the previous year.[10]

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[10] General Accounting Office, *Factors Contributing to Low Use of Dental Services by Low-Income Populations* (Sep. 2000).

A major cause for this lack of participation is that Medicaid substantially underpays for dental services. Only 13 states pay fees that exceeded two-thirds of the average regional fee charged by dentists, according to the GAO study. This threshold is significant because GAO found Medicaid programs paying at least two-thirds of the regular fee were far more successful in recruiting dentists than those that did not.[11]

The Michigan Experience

In May 2000, Michigan launched a pilot program, the Healthy Kids Dental Program, to improve dental services and expand access to dental services for poor children in several locations in the state. The program, which was designed with input from the state's Head Start leaders, reimburses providers at commercial rates. Within eight months, data show that utilization has improved 78.7% among Medicaid-eligible children in the pilot areas, and provider participation has increased by 43%. As a result, poor children in the pilot areas in Michigan have many more options for enrolling to receive dental services.

Source: American Academy of Pediatric Dentistry, *"Filling Gaps" Task Force Visit to Michigan Healthy Kids Dental Program* (Nov. 12-13, 2001).

Children's dental services are especially underfunded. The Surgeon General reported that about $17 to $21 dollars per child per month should be set aside for dental services. Medicaid programs, by contrast, spend on average only $4.44 per enrolled child per month.[12] According to the National Health Law Program, there have been at least 21 lawsuits in 17 states against state Medicaid programs for inadequate dental services. Of these, 16 have been settled or decided — all in favor of the plaintiffs.[13]

With increased fees and reduced administrative burdens, some states, such as Michigan, Alabama, South Carolina, Delaware, and Georgia, are improving dentist participation in Medicaid programs.[14] However, these efforts have not been duplicated on a broader scale.

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[11] *Id.*

[12] *U.S. Surgeon General, supra* note 1, at 254.

[13] National Health Law Program, *Docket of Medicaid Cases Filed to Improve Dental Access* (Oct. 19, 2001) (online at www.healthlaw.org/pubs/dentaldocket.html).

[14] Letter from Dr. Burton Edelstein, Children's Dental Health Project, to Rep. Henry A. Waxman (Apr. 8, 2002).

Shortages in the Dental Workforce

A second cause of difficulties in access to dental services for Head Start children is the shortage of dentists around the country, which leaves many communities almost devoid of accessible practitioners. The Surgeon General estimated that 25 million Americans live in areas that do not have access to adequate dental services.[15] Federal initiatives to place health professionals in underserved areas include the National Health Service Corps and the Indian Health Service. However, GAO identified lack of federal funding as a reason for empty spots for dentists in both of these programs.[16] The shortage of pediatric dentists is particularly acute. There is only 1 pediatric dentist for every 13 pediatricians.

Inadequate Services at Community Health Centers

Many poor children rely on community health centers for dental and other services. But in September 2000, GAO found that a little more than half of 700 federal community health center grantees offered dental services. GAO also found that those centers offering dental care experienced long waiting periods for appointments.[17] The Health Resources and Services Administration subsequently has increased funding for oral health initiatives.[18] However, experts believe that significant gaps will still remain.

REPUBLICAN PROPOSALS TO OVERHAUL HEAD START PUT PROGRESS AT RISK

Congress is currently debating legislation, supported by the Bush Administration, that would radically overhaul the Head Start program. The legislation was passed by the House Committee on Education and the Workforce on June 19, 2003, on a party-line vote.[19] The full House will soon debate the legislation.

The legislation would turn the Head Start program, which is now a federal program, into a state block grant in certain states. Under the legislation, up to eight states would be allowed to accept federal funding for the program, but would no longer be subject to federal requirements, such as those that require

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15 *U.S. Surgeon General, supra* note 1, at 9.

16 *General Accounting Office, supra* note 8.

17 *Id.*

18 In Fiscal Year 2002, the Health Resources and Service Administration will spend $25.5 million for oral health programs.

19 The legislation, H.R. 2210, was passed by the Committee by a vote of 27-20, with 27 Republicans in favor and 20 Democrats against.

programs to help preschool students obtain adequate dental care.[20] The legislation would also allow states to divert funds from the Head Start program to other early childhood programs in the state.

Presently, Head Start programs are required to meet eight performance standards for comprehensive services in areas such as medical and dental care. These standards require that children in the program receive assistance when necessary. For example, according to the program's rules, Head Start staff are directed to find dental services for enrolled children, even if this means locating dentists, making appointments, providing transportation, and even paying for services. But according to the National Head Start Association, the Administration proposal "does nothing to ensure that states will be required to or be capable of providing these services to Head Start-eligible children, especially in a time of serious budget deficits."[21]

The end result would be that the legislation would put in place "a hodgepodge of inconsistent and untested state government programs that either will serve fewer children than Head Start does now or will provide less comprehensive services to those children who are served."[22] This would mean that many of the benefits that children in Head Start receive in obtaining dental care would be eliminated.

CONCLUSION

Head Start provides significant benefits to poor children in need of dental services, with children in the program twice as likely to receive needed dental care as other poor children. However, while Head Start's efforts to assure that children receive dental services have significant benefits for poor families, the program's efforts are limited by systemic problems in access to care. These problems include inadequate Medicaid reimbursement, gaps in the dental health workforce, and inadequate services in community health centers. Proposals by the Bush Administration and by Republicans in Congress would increase these barriers, and make it even more difficult for children in Head Start to receive necessary dental care.

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[20] Analysts have indicated that the eight-state pilot program is "a precursor to transforming the entire program into block grants." *House Panel Approves Revisions for Heath Start*, Washington Post (June 13, 2003).

[21] National Head Start Association, *Dismantling Head Start: The Case for Saving America's Most Successful Early Childhood Development Program* (Apr. 2003).

[22] *Id.*