



Улучшение доступа к уходу за полостью рта для взрослых с ограниченными возможностями

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Improving Access to Oral Health Care for Adults with Disabilities Can Improve Their Health and Well-Being

Many adults with disabilities experience extraordinary barriers to good oral health. There are several reasons for this: These adults often lack insurance for oral health care because Medicare does not cover dental care, and because, in many states, Medicaid does not meet adults' dental needs either. In addition, few dental offices provide accommodations to serve adults with physical or other disabilities.

This is a serious problem. Without oral health care, people with disabilities face challenges to maintaining their overall health. Many chronic conditions are linked to oral health and can be better managed when oral health problems are treated. Other health conditions, and the medicines used to treat them, can also cause or exacerbate oral health problems. Poor oral health can impede people's ability to eat, interact socially, get a job, and feel well – adding to the difficulties people with disabilities already face in daily life. Policy changes at the federal and state levels, as well as adoption of best practices by providers and programs could improve care for those adults.

In this brief, we examine the significant gaps in Medicare and Medicaid coverage of oral health care; explore why obtaining good oral health care

is particularly important to adults and children with disabilities; discuss how dental offices often do not accommodate the needs of people with disabilities; explain the progress that is being made in providing such accommodations; and lay out the opportunities at the federal and state level for improving oral health coverage.

Medicare and Medicaid Leave Significant Gaps in Oral Health Coverage for People with Disabilities

Medicare covers many health care services – but not oral health care – for many people with disabilities

About 8 million adults under age 65 receive Medicare for both inpatient and outpatient care (Parts A and B) based on their disabilities.¹ About 4 million of these

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adults have low incomes and therefore qualify for both Medicare and Medicaid. Medicare pays a portion of their hospital, doctor, and prescription drug costs, and Medicaid pays most of their coinsurance and other out-of-pocket costs that they would otherwise face.

For the most part, people under age 65 with Medicare are adults who have worked until they became disabled (or they are survivors of a spouse who worked). After becoming disabled, most must wait 29 months to qualify for Medicare.* Their disabilities are long-lasting. In total, about two-thirds of Medicare beneficiaries under age 65 have a cognitive or mental impairment that interferes with daily activity.² The other one-third have a variety of physical impairments that significantly limit their ability to work, resulting from birth or from injuries or from diseases. People who have had a disability since childhood can get Medicare as adults if they have a parent who receives Social Security retirement benefits, or if they are getting Social Security survivor benefits because their parent has died.

Though the adults with disabilities described above receive coverage for most outpatient care, preventive services, and other medically necessary care through Medicare, it does not cover oral health care. Generally, Medicare does not cover preventive dental services (like exams and cleaning), treatment of oral health conditions (such as scaling, root planing and/or

antibiotics for people with gum disease) or filling and restorations. Without including these services, Medicare leaves an important part of the body almost completely uncovered—the mouth. This has a major impact on overall health.

Medicaid oral health coverage for adults varies from state to state and is often inadequate

More than 10 million adults with disabilities qualify for Medicaid because they have low incomes in addition to their disabilities. Approximately 4 million of these adults are dually eligible for both Medicare and Medicaid. About 6 million receive only Medicaid because they do not have the Social Security work record needed to qualify for Medicare, or because they have not yet satisfied the 29 month waiting period.

Whether Medicaid covers adult oral health care, and what sorts of dental care it covers, varies from state to state. As of November 2018:

- » three states provided no dental benefits to adults with Medicaid
- » 12 states provided “emergency only” care to relieve pain in specific emergency situations
- » 17 states covered only some dental procedures and/or have an annual cap of \$1,000 or less per person
- » 19 states (including the District of Columbia) covered more extensive dental services³

* Most people must wait five months after the onset of a disability to qualify for Social Security Disability Insurance, and then another 24 months after that to get Medicare. People with [end stage renal disease \(ESRD\)](#) or [ALS \(amyotrophic lateral sclerosis\)](#) qualify sooner. For more information, [see the Social Security website](#).

Medicare Beneficiaries with Disabilities Commonly Have Chronic Conditions That Make Access to Oral Health Care Even More Important

Medicare beneficiaries with disabilities commonly have multiple chronic health conditions. Some of the most prevalent chronic health conditions among people on Medicare with disabilities have strong connections to oral health. Yet without dental coverage, these beneficiaries are likely to go without needed oral health care.

For Medicare beneficiaries who are under age 65 and getting Medicare based on a disability, prevalent chronic conditions that have known oral health connections include the following:

Depression is a chronic condition for 31 percent of the beneficiaries in this group.⁴ Antidepressants often cause dry mouth, which may result in painful mouth sores and lead to cavities and enamel erosion. On the other hand, research has found that dental conditions can exacerbate depression, given the connections between oral health and self-esteem, employability, social isolation, and overall health. For example, studies show that poor oral health increases the likelihood of a person being depressed.⁵ Furthermore, oral pain and embarrassment about missing teeth or appearance can also impede behavioral health recovery.⁶

Diabetes is a chronic condition for 27 percent of the beneficiaries in this group.⁷ Connections between periodontal disease, gingivitis and diabetes are well established in clinical research. These oral health problems worsen diabetes, making it harder to control blood glucose. The reverse is also true: Diabetes

worsens oral health and increases the need for regular oral health care.⁸

Because of this strong association, some Medicare Advantage plans have found it cost effective to pay for oral health care as an added benefit that is not normally covered by Medicare. Unfortunately, this oral health coverage is not available to most Medicare recipients.⁹

Kidney disease is a chronic condition for 22 percent of the beneficiaries in this group.¹⁰ A proper diet (which is easier to eat with a healthy mouth) can help slow the prevalent diseases that lead to end stage renal disease (ESRD). When poor oral health limits a person's ability to bite and chew, it is harder for them to eat a nutritious diet. Furthermore, poor oral health can alter the proteins and glucose in the blood, which compromises good medical outcomes for patients with ESRD.¹¹ For example, because oral infections can increase surgical risks and be fatal to transplant patients, ESRD patients must show that they have good dental health in order to get a clearance for a kidney transplant (one of the common

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treatments for ESRD). Ironically, Medicare will pay for medical clearance exams, but it does not pay for treatment of any dental problems the exams detect.

Some Adults with Disabilities Have Had Conditions Since Childhood That Compromise Their Oral Health. Once They Reach Adulthood, It Is Even Harder to Find and Pay for Oral Health Treatment.

For children who have health coverage through Medicaid or the Children’s Health Insurance Program (CHIP), every state Medicaid program must cover a broad range of oral health services as part of the Early Periodic Screening, Diagnosis, and Treatment provision that applies to all children until age 21. This coverage protection is in marked contrast to the gaps in oral health coverage for adults. For children, covered services include treatment of pain and infections, restoration of teeth, and maintenance of dental health. Oral health care must be provided regularly based on a schedule that is recommended by pediatric dental organizations.

Unfortunately, federal policies do not continue these Medicaid coverage and access protections into adulthood. So, a person who has grown up with disabilities and received dental services through Medicaid as a child may find themselves suddenly without access to Medicaid-covered dental care – or any other affordable dental care – as an adult.

Epilepsy is an example of a disorder that often starts in childhood and lasts into adulthood (though it may have its first onset later in life). About 3 million adults have active epilepsy. In the 18-64 age group, about 17 percent of these adults have health coverage through Medicare alone or in combination with Medicaid.¹² Another 25 percent of these adults have health coverage through Medicaid alone.¹³

Medications for epilepsy, like those for many chronic conditions, contribute to tooth decay. In addition, seizures can directly harm oral health through trauma, which can require immediate dental care and follow up. For example, people may need dental care to replace or preserve a missing tooth, to treat a laceration, or to treat [trauma-induced TMJ \(temporomandibular joint\)](#) disorders, and they may need mouth guards to prevent some of these injuries.

Medicare does not cover any of these kinds of oral health care. Whether Medicaid covers such services for low-income adults varies by state. But in every state, under federal law, Medicaid covers these services for low-income children.

Similarly, **autism spectrum disorders** can have direct oral health consequences. Some people with autism may grind their teeth (bruxism), have limited dietary preferences (such as only pureed food) that can harm teeth, may take medications that exacerbate oral health problems, and/or may not receive the supports

they need to complete daily oral hygiene (such as brushing their teeth).¹⁴

Adults who qualify for Medicaid and/or Medicare due to intellectual disabilities that they have had since childhood may rely on caregivers to assist them with daily oral hygiene or to get them to dental appointments. Once in the dental office, they may need extra time or accommodations. The lack of dental coverage, lack of providers with accommodations, and reliance on caregivers or service providers who may not be able to prioritize their oral health all take a toll. For all of these reasons, oral health ranks among the most prevalent unmet health care needs of people with intellectual disabilities.^{15, 16}

In Addition to Coverage, Adults with Disabilities Need Dental Care That Accommodates Their Needs

The accommodations that people may need to achieve optimal oral health vary among people with congenital, acquired, physical and intellectual disabilities. Examples of the accommodations some people with disabilities need include the following:

- » Dental offices that are wheelchair-accessible
- » The option to remain in their wheelchairs for dental services instead of transferring to the dental office's chair
- » Help or adaptations to hold a toothbrush
- » A home care worker or other caregiver who is trained to help them brush and to be attentive to their oral health needs
- » Extra time and emotional support once in a dental chair

The lack of dental coverage, lack of providers with accommodations, and reliance on caregivers or service providers who may not be able to prioritize their oral health all take a toll.

- » Sedation, a service animal, or acupuncture to withstand dental treatment¹⁷

Others may not need any accommodations, but do need dental professionals and other health care providers to be aware of the interactions between their oral health and their other physical and behavioral conditions—and to be educating their patients about these interactions.

Examples of Progress in Providing Accommodations for Patients with Disabilities

Some communities and dental programs have made wonderful progress in providing accommodations for their patients with disabilities. Unfortunately, these measures are not yet widespread.

Promising initiatives that can serve as models for other states and for the nation include:

- » **Instituting educational requirements for dental professionals:** In 2020, all accredited dental schools in the U.S. will provide training to dental students on how to treat patients with intellectual or developmental disabilities. The

Commission on Dental Accreditation announced this change in August 2019.¹⁸

At the state and local levels, communities can similarly require continuing education for the current dental workforce regarding patients with special needs. The Special Care Dentistry Association has developed an online continuing education program for dentists and their staffs in meeting the oral health needs of people with disabilities. This program is available nationwide.¹⁹

- » **Reimbursing providers to treat adults with disabilities:** Certainly, the best state policies provide Medicaid dental coverage to all low-income adults while also paying participating dental providers enough to assure provider participation. State Medicaid programs should cover an extensive range of services, including prevention, restoration and replacement of teeth, and should ensure that providers are available for each of these service needs. They should reimburse sufficiently to ensure that specialty dental providers are available, equipped to serve patients with disabilities from their wheelchairs and to provide the full range of needed services.

Since 2007, New Mexico has reimbursed dentists who serve people with developmental disabilities under a special procedures code once they have completed a training and certification program. This initiative has demonstrated that most people with a developmental disability can be treated in a traditional dental setting.²⁰

South Dakota allows dentists to bill to a “behavioral code” for the extra staff time that may be involved to provide supportive

States, communities, health plans, and dental professionals can each take steps to better accommodate patients with disabilities.

care for some people with developmental disabilities.²¹ For instance, it may take extra time to get the patient comfortable, explain what is going to happen and demonstrate what the patient should do, work with someone who has uncontrolled body movements, and provide frequent breaks for the patient to relax.

Medicaid managed care plans can themselves initiate improvements in care for people with disabilities. In the Philadelphia area, AmeriHealth Caritas, a managed care organization, was inspired by [project Accessible Oral Health](#), a global public-private partnership, to pursue equal access to culturally competent oral health care. AmeriHealth Caritas launched their Inclusive Dental Plan in April 2019 to expand the network of dental providers who are committed to public health and to accessible care for people with disabilities. Eventually, they hope to implement the program in other markets beyond Southeastern Pennsylvania and extend it to Medicaid, Medicare, and managed long-term services and supports plans. The Inclusive Dental Plan uses a new reimbursement structure that recognizes the more intensive time commitments that may be involved in

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making care accessible. AmeriHealth Caritas will partner with dental schools to establish a variety of training courses that will support dentists, hygienists and other staff.²²

States that provide dental care to Medicaid enrollees through managed care plans can require the plans to take action to improve access to dental care without proscribing the specific intervention: states can make accessible dental care a network adequacy requirement.

Some states have worked to improve access to dental care for people who need long-term care supports, even if those states do not have broader initiatives to improve oral health access for people with disabilities. States can use Medicaid home- and community-based care waivers to enhance dental services for people with special needs, paying higher rates to dentists through that waiver or reimbursing for additional services. The District of Columbia and Missouri both use this approach.²³

New care delivery models can also help. For example, Minnesota's AppleTree Dental uses mobile dental offices with workforce teams that include advanced dental therapists and dental hygienists practicing at the top of their licenses. Medicaid pays for the services AppleTree

delivers in long-term care facilities as the facility's "dental director."²⁴

» **Integrating primary, specialty, and oral health care:**

Primary and specialty care providers can help screen patients with disabilities for oral health problems and refer them to dental providers as needed.²⁵ Many community clinics now include dental professionals on their staffs, which makes the referral process easier.

Hospitals can also integrate oral health services. For example, when the Department of Veterans Affairs (the VA) realized that hospital-acquired pneumonia originates from bacteria in the mouth, it developed protocols for hospital staff to provide oral care to inpatients and to teach patients, families and caregivers how to provide oral health care when patients are discharged.²⁶

» **Helping and supporting caregivers and individuals to attend to oral health needs:**

The Alzheimer's Association provides resources for caregivers of people with dementia to help these caregivers manage both daily care and dental appointments.²⁷ Other associations can opt to provide similar caregiver resources for patients with other conditions. Community health workers can also provide valuable help and support to caregivers and people

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with disabilities about oral health care. And occupational therapists can help adapt self-care techniques for people with disabilities and their caregivers (for example, by providing simple devices to make it easier to hold a toothbrush, or by teaching techniques to manage hypersensitivity that makes brushing painful).

- » **Using other agencies to assist with care coordination:** In California, many regional centers that coordinate services for people with developmental disabilities employ dental coordinators to help find dental providers who accept Medicaid, assist the dental offices with administrative tasks to encourage them to participate in Medicaid, train consumers and residential care providers on oral hygiene, and coordinate desensitization (which puts patients at ease before dental procedures). However, a Legislative Analyst's Office report explains that, while these steps do help, more must be done to improve coverage and further access.²⁸

- » **Educating patients and providers:** Patient organizations such as the American Heart and Stroke Association, the American Diabetes Association, and Autism Speaks are increasingly posting materials on their websites that educate the public about the connections among various medical conditions and oral health. The University of Washington and the Washington Dental School have developed fact sheets for dental professionals, medical professionals, parents, and caregivers about how a number of health conditions interact with oral health and what that means for care.²⁹

Oral Health Coverage is Fundamental to Receiving Accessible Care

Oral health coverage is fundamental to receiving accessible care. We recommend:

- » Every state Medicaid program should provide comprehensive dental care to adults, and should monitor whether that care is in fact accessible to people with disabilities.
- » Medicare Part B should cover preventive, acute, and restorative dental care.

There Are Opportunities for Improving Coverage at the State and Federal Levels

There is hopeful news at the federal level and in some states about improving coverage for adult oral health care.

At the federal level, there are several promising developments:

- » The U.S. Surgeon General will be releasing an updated report in fall of 2020 regarding the nation's oral health and its importance.
- » As of summer 2019, four bills have been introduced in Congress that would add a comprehensive oral health benefit to Medicare Part B.³⁰ A broad coalition supports these bills.
- » Another coalition of organizations has been talking with the Centers for Medicare and Medicaid Services (CMS) about allowing coverage of certain medically essential oral health services for people with serious illnesses under existing law.

At the state level, the news from the 2019 legislative sessions is mixed:

- » Delaware added an entirely new set of benefits for oral health care for adults to its Medicaid program.
- » Nine states, Colorado, Kansas, Nevada, New Hampshire, Texas, Utah, Vermont, Virginia, and Washington took small steps toward enhancing their state's adult oral health coverage.
- » Alaska eliminated the dental benefits that its Medicaid program had provided to adults.³¹

Improving coverage and maintaining good coverage programs take work by the concerned public, elected officials, and state and federal administrators. To receive updates or join our coalition, [visit Families USA's Oral Health for All Campaign page](#).

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