NOHC Pre-Conference Session
“Oral Health Policy to Practice”

April 28, 2012
Marcy Frosh & Colin Reusch
Children’s Dental Health Project
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AR-12: Lobbying Restrictions

http://www.cdc.gov/od/pgo/funding/grants/additional_req.shtm#ar12

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What is Policy?

• Most broadly, policy can be a **GOAL** for action or the actual **RULES** that set a course of action.

• Institute of Medicine (IOM) describes policy development as an **essential public health function**

• CDC core domain is **Policy, Systems, and Environmental change (PSE)**
The Policy Assessment Tool is a framework for aggregating stakeholder input
A few basics on “Tool” experience:

- 18 states between 2007-2011 (4 states twice)
- Facilitated process with < 10 to > 100
- More than 270 suggested priorities between 2009-2011 alone
- Few states otherwise conducted policy assessment
- Transparent process that builds trust and consensus
- EDUCATES AND ENGAGES STAKEHOLDERS!
Bringing a range of stakeholders to the oral health “table”

- Oral health coalition members & SOHP staff
- Aging groups
- Children & family groups (WIC / Head Start)
- Dental professional associations
- Safety Net
- Medicaid/Medicare and/or CHIP
- Philanthropies
- Academics
- Chronic disease agencies and groups
- Health consumer groups
- Other
Stakeholder analysis is recommended!

Tool organizers are encouraged to create an ad hoc committee to ensure broad-based participation in the activity!
Post-Survey Feedback Snapshot:

- 99% of respondents said the structure of the Tool elicited high stakeholder participation
- 95% of respondents said the structure allowed for substantive communication (Note: potential to educate non-oral health partners!)
Background on the Policy Tool

• Part I consensus scoring based on 2 sets of criteria: opportunity for public health impact + feasibility

• Part II is a “next steps” checklist

• Facilitator completes a report on the process
Policy Assessment Tool:
Step 1

Create a consensus list of opportunities for the Tool activity

1
2
3
4
5
Step 2: Four questions for each of the five opportunities

- What is the extent of the **problem** (as quantified through **data** sources that the policy or systems opportunity would address?)

- How **urgent** is the need for policy or systems change addressed by the opportunity?
Step 2 (cont’d)

• To what extent does the **community perceive a need** for a policy or systems change (e.g., based on surveys or media reports)?

• To what extent will the policy or systems change **reach and be effective** for the intended **target population**?
Step 3: Rate the 5 opportunities: Feasible in the real world?

- Available resources (e.g., public/private funding)
- Recognized support from agenda setters*
- Past policy focus
- Regulatory impact (e.g., scope of practice)
- Strength of public voices pro and con
- Strength of partnerships
- Timing
- Other areas of influence

STAKEHOLDER PRIORITIES (2009-2011)

Of ~270 different suggested opportunities, most duplicated are:

- **Developing a public education program on oral health**
- **Creating modalities for cross-disciplinary training on dental issues**
Policy Assessment Tool: Part II

Strategy:
- Capitalize on existing opportunities
- Create new opportunities

Limitations:
- State-specific restrictions
- Federal restrictions
Part II Checklist:

- Clarify the goal (a SMART objective is specific, measurable, achievable, realistic, & timed).
- Know the costs.
- Establish a clear argument.
- Develop a broad base of support.
- Assess the environment.
- Identify champions.
- Identify opponents.
- Past efforts in your state – lessons learned?
Part II – (cont’d)

- What are other states are doing – lessons learned?
- Develop a clear and succinct message.
- Identify effective message bearers (not always obvious).
- Identify supporting strategies.
- Ensure strategies are in compliance and appropriate.
- Refine – are strategies following SMART goals and is everyone on message and in sync?
- Implement.
- Evaluate.
Part II Example: Develop Your Message

-- BE SUCCINCT & SUBSTANTIATE NEED!
“Policy has always been a difficult area for us – it’s rally hard to sell to stakeholders without a process like this.”
We’ll see from North Dakota how disease burden data and needs assessment information informs the Tool session and helps to build oral health champions.
What else supports policy assessment?

SCAN of past policies and systems in place:

- New partners are unlikely to be aware of existing policies
- Long-standing partners may be unclear
- Education/Outreach requires up-to-date information
Status of state-by-state oral health policy scan:

- 50-state database (e.g., NCSL) on comprehensive oral health topics is not yet available
- Scans of state legislation by year are available for some topic areas:
  - Nat’l. Assoc. of Community Health Centers
  - American Dental Hygienists Association
  - Other
Environmental Health Legislation Database

Search Results 137 bills in 24 different states  Return Colorado Connecticut

Bill Text Lookup CT H 6539 Environmental Health 2009 Status: Enacted -
  Public Act No. 220 Date of Last Action: 07/08/2009 - Enacted*
  Author: Joint Public Health Topics: Children's Environmental Health | Indoor Air Quality | Indoor Air Quality – Radon
  Summary: Concerns environmental health, eliminates the December 31, 2008,
  deadline for the Commissioner of Public Health to establish and define
  categories of discharge that constitute alternative on-site sewage
  treatment . . .

History: Click for History
Scanning by individual State can capture a range of policies

For example:

• Professional policies – (e.g., Perinatal Guidelines)

• Public policies in laws, regulations, other (e.g., statewide fluoridation mandate)

• Programmatic policies (e.g., MOU with Dept. of Environment)
Maryland’s Approach

• Finding information to populate tracking sheet:
  – Original tracker in use
  – Policy white papers
  – Maryland General Assembly website
  – Dental Action Committee recommendations
Maryland Approach: Methods

• Need for user-friendly tool:
  – Organize past legislation
  – Update easily
  – Identify instances of public/programmatic/professional overlap
TOOL RECAP:

• Oral Health Policy Assessment Tool is an opportunity for **open and transparent communication** on stakeholder policy/systems priorities based on a facilitated process

• The process educates about oral health and has the potential to **build oral health champions**

• **Information on the status of current policy** is critical for stakeholders participating in the Tool process
THANK YOU!

Find the CHILDREN’S DENTAL HEALTH PROJECT (CDHP) at: www.cdhp.org
Opportunities for State Policymakers to address Quality Measurement in Dental Care Delivery Systems

Meg Booth, MPH
National Maternal & Child Oral Health Policy Center
Children’s Dental Health Project
• Goal 1: **Enhance Knowledge.** Identify, analyze, and promote new information for policymakers and key stakeholders to improve MCH oral health policies and practices.

• Goal 2: **Build Capacity.** Build awareness, skills, and knowledge among policymakers and key stakeholders to actively promote new and effective oral health policies.

• Goal 3: **Expand the Community.** Expand and diversify the audience engaged in promoting oral health of MCH populations.
Engagement of The Policy Center in Quality

• Increasing awareness of the growing number of quality initiatives that included oral health (public and private)

• The Policy Center was often contacted regarding specific quality measures

• Needed a better sense of the scope and breath of the oral health quality initiatives

• Wanted to better understand the policy opportunities and implications for state policymakers
Initial Exploration of Quality

In July 2011, The Policy Center convened the

*Ad Hoc Workgroup on Aligning Dental Quality Initiatives*

Participants included: state policymakers, federal agencies, dental organizations, dental benefits companies, large group dental practices, academe

**Goals:**

1. Assess the current state of dental quality efforts
2. Identify what should be in place in terms of dental quality
3. Locate the gaps in the existing dental quality initiatives

Identified the current or potential “Drivers” to encourage attention to dental quality efforts and the significant barriers or “Drags” to implementing quality measurement efforts
Consensus to advance quality measurement efforts included:
  – Improved data collection
  – Defining the dimensions of dental quality
  – Communication about the ongoing dental quality efforts
  – Development of common vocabulary including terms such as “quality and “systems of care”

Next Steps: The Policy Center encouraged and worked with philanthropy (DentaQuest & Kellogg) to launch the follow-up national discussion on quality
TrendNotes has been The Policy Center publication is designed to focus policymakers’ attention on the trends, opportunities and policy options to improve oral health for all children at lower cost through the best use of prevention, disease management, care coordination, and maximized resources.

Soon to be released…. Quality Improving in Children’s Oral Health: Moving from Volume to Value

– Framework built from The Triple Aim and IOM report on Crossing the Quality Chasm
  1. Apply evidence to health care delivery
  2. Align payment policies with quality improvement
  3. Use information technology
  4. Preparing the workforce
Implications for Policy and Practice

- Create payment incentives to report oral health quality measures and quality improvement efforts in public programs (Medicaid & CHIP) that focus on the health outcomes of children.
- Integrate oral health into state and local healthcare quality improvement initiatives.
- Integrate oral health information within electronic health records and ensure that dental providers are included in health information exchanges.
- Strengthen state oral health agencies to create, collect and monitor data on the oral health status of children over time to identify improvement in long-term health outcomes.
- Align state policy to take advantage of federal programs that encourage alternative strategies to improve health outcomes.
- Encourage dental training programs to promote interdisciplinary teams and new training that emphasized the health outcomes of children and families.
What have we learned?

• Complex web of interests and players contemplating quality measurement

• Extensive list of measures, but few measures of health outcomes

• Greater urgency is being detected with the lack of consistent standards to detect and demonstrate fraud in public programs

• There is going to have to be a greater demand for change by at least one player (consumer, provider, or payor) to move quality measurement forward
Resources

• National Maternal and Child Oral Health Policy Center
  www.nmcohpc.org

• Children’s Dental Health Project
  www.cdhp.org

Meg Booth
mbooth@cdhp.org
Ph. 202.417.3598
Dental Literature and Evidence on Social Determinants of Oral Health

National Oral Health Conference
May 2, 2012

Presenter
Anupama Rao Tate, DMD
Senior Policy Fellow
Children’s Dental Health Project
Why use a life course perspective?

• Life course Perspective
  – Time
  – Variation in determinants over time
  – Long term influences
  – Accumulation of protective factors

• Relationships between time and health
  – Fetal period- later life
Why discuss determinants of health?

- Dental services alone cannot assure oral health of children and adults

- Change in socioeconomic status is complex, but has the “greatest potential impact” to improve health
Frieden Framework

FIGURE 1—The health impact pyramid.
Socioeconomics and Illness: Long Recognized

Example:

*Health and Ways of Living: The Alameda County Study*

*Authors: Berkman and Breslow (1979)*
Attempts to DEFINE “determinants” of health

- Ansari (2003)
  - Four major groups
- Rose (2005)
  - Causes of causes
- Wilkerson and Marmot (1998)
  - 10 messages
- Bravemen and Gruskin (2003)
  - Key social determinants
  - Access to common needs
Literature on determinants of oral health prior to Year 2006

  - Psychosocial models predicting caries
• Pattussi MP, et al. Social Deprivation, income inequality, social cohesion and dental caries in Brazilian school children. *Social Science and Medicine*; 2001
  - Impact of inequality on dental caries
Literature on determinants of oral health prior to Year 2006

• Klemme B, et al. Relationship between caries prevalence and fissure sealants among 12 year old German children at three educational strata. *Soz. Pravenentivemed* 2004
  - Higher DMFT
  - Followed a birth cohort
  - Life course approach
A current conceptual model: 2006

Fisher-Owens, Pediatrics 2007
A current conceptual model: 2006

Fisher-Owens, Pediatrics 2007
A current conceptual model: 2006

Fisher-Owens, Pediatrics 2007
Review of Literature

Fisher-Owens, Pediatrics 2007
Assessing the Fisher-Owens Model

  - Study 22 domains across 4 levels
  - Results
  - Conclusions
Additional work:

- Brennan DS, Spencer AJ. Life events and oral-health-related quality of life among young adults. Qual Life Res. 2009. (South Australia)
  - Positive life events and OHRQoL

  - Studied protective/negative social factors and oral health
* Students who graduate with a regular diploma 4 years after starting 9th grade (AH-5.1)

See:
Socioeconomic factors and Early Childhood Caries (ECC)

- Parental education below High School level
- No family dental care
- Rural
- Without insurance

http://www.aap.org/oralhealth/pact
Recognizing public health efforts that already incorporate determinants

- Efforts to date on State Oral Health Plan HP2020 goal setting?
- What integration/collaboration exists in current activities?
- What current interventions address determinants (e.g., motivational interviewing)
- Other?
NEXT STEPS:

• Develop, implement, and test family-based dental-medical
• Focus on prenatal and early childhood mental, physical and social health as a foundation for families to reduce risk of oral disease
• Expand scope of study of social determinants to include stress (e.g. occupational), discrimination, role of other chronic diseases, and other bio- or psycho-social factors.
• Incorporate determinants in other modeling efforts (e.g., Systems Dynamics)
• Develop curriculum
Oral Health Provisions in The Affordable Care Act: Controversies and Actions Taken

April 29, 2012

Colin Reusch
Children’s Dental Health Project

Penny Anderson
Maryland Dental Action Coalition
Taken together (funded and unfunded), the 23 oral health provisions in ACA offer an integrated and comprehensive plan to address:

PREVENTION & HEALTH PROMOTION  
COVERAGE & FINANCING  
DELIVERY SYSTEM/SAFETY NET  
INFRASTRUCTURE & SURVEILLANCE  
WORKFORCE & TRAINING
Oral Health Provisions in the ACA

- Funded or Mandatory
- Partially Funded
- Unfunded
## Prevention & Health Promotion

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Caries Disease Management</strong></td>
<td>Establishes a national grant program to demonstrate the effectiveness of research-based dental caries disease management</td>
</tr>
<tr>
<td><strong>School-based Dental Sealant Programs</strong></td>
<td>Requires that states receive grants for school-based dental sealant programs</td>
</tr>
<tr>
<td><strong>Oral Health Public Education Campaign</strong></td>
<td>Requires HHS Secretary to establish a 5-year public education campaign to promote oral health</td>
</tr>
<tr>
<td><strong>Prevention and Public Health Trust Fund</strong></td>
<td>Establishes a fund to provide an expanded and sustained national investment in prevention and public health programs – may include oral health. Appropriates the following amounts to the PPHF: FY2010 = $500 million; FY2011 = $750 million; FY2012 = $1 billion; FY2013 = $1.25 billion; FY2014 = $1.5 billion; FY2015 and each fiscal year thereafter = $2 billion.</td>
</tr>
<tr>
<td><strong>National Prevention, Health Promotion, and Public Health Council</strong></td>
<td>Charged with coordinating Federal prevention policy and developing a national prevention strategic plan</td>
</tr>
<tr>
<td><strong>Community Transformation Grants</strong></td>
<td>Establishes grants to state and local agencies and community organizations for prevention efforts outside the doctor’s office. Funded through the Prevention and Public Health Trust Fund at $221 million for FY 2011 &amp; 2012</td>
</tr>
</tbody>
</table>
### Effective Coverage

<table>
<thead>
<tr>
<th>Star</th>
<th>Oral Health Services for Children</th>
<th>Requires State Exchanges to include oral health services to children as part of the Essential Health Benefits Package</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stand-Alone Dental Plans</td>
<td>Allows stand-alone dental plans with pediatric benefits to participate in State Exchanges</td>
</tr>
<tr>
<td></td>
<td>MACPAC Reporting on Dental Payments</td>
<td>Requires MACPAC to review payments to dental professionals and report to Congress: $9 million for FY 2010 to remain available until expended</td>
</tr>
<tr>
<td></td>
<td>CHIP Maintenance</td>
<td>Funding made available through FY 2015 – increased federal assistance in FY 2016 , CHIP maintained until 2019</td>
</tr>
<tr>
<td></td>
<td>Medicaid Expansion</td>
<td>Expands Medicaid coverage to individuals whose income is 133% of FPL or less.</td>
</tr>
<tr>
<td><strong>Alternative Dental Health Care Providers</strong></td>
<td>Establishes a 15-site demonstration project to train or employ alternative dental health care professionals</td>
<td></td>
</tr>
<tr>
<td><strong>National Health Care Workforce Commission</strong></td>
<td>Establishes the Commission and makes the oral health care workforce a high priority for review</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Training Programs</strong></td>
<td>SEC 5303 - General, pediatric, and public health dentistry training program funded at $30 million for FY 2010.</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Residency Programs</strong></td>
<td>Establishes three-year, $500,000 grants for new primary care residency programs, including oral health Funded through the Prevention and Public Health Trust Fund for FY 2010 at $168 million.</td>
<td></td>
</tr>
<tr>
<td><strong>Graduate Medical Education Programs</strong></td>
<td>Provides funding for new and expanded graduate medical education, including dental education</td>
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</tbody>
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# Delivery System

## Federally Qualified Community Health Centers

- **Community Health Center Fund (CHCF):** Establishes a CHCF and appropriates a total of $11 billion over the five-year period FY2011 through FY2015 to the fund, to be transferred by the Secretary to HHS accounts to increase funding, over the FY2008 level, for (1) community health center operations; and (2) NHSC operations, scholarships, and loan repayments.

  - **Health center construction and renovation:** $1.5 billion, to be available for the period FY2011 through FY2015, and to remain available until expended.

## School-based Health Centers

- **Grant program for the establishment of school-based health centers for facility construction, expansion, and equipment:** $50 million for each of FY2010 through FY2013, to remain available until expended.

  - Expands school-based dental sealant programs to all states, territories and tribes (unfunded)

  - Provides Grants to SBHCs for operations and includes oral health services in qualified services provided by SBHCs (unfunded)
## Infrastructure, Quality & Surveillance

<table>
<thead>
<tr>
<th>Oral Health Infrastructure</th>
<th>Requires the CDC to provide cooperative agreements to states for improving oral health infrastructure (from 19 states → 50 states, territories, &amp; tribes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Risk Assessment and Monitoring System</td>
<td>Requires that oral health measurements be included in PRAMS</td>
</tr>
<tr>
<td>National Health and Nutrition Examination Survey</td>
<td>Retains “tooth-level” surveillance in NHANES</td>
</tr>
<tr>
<td>Medical Expenditure Panel</td>
<td>Requires a “look-back” validation for dental - parity with medical</td>
</tr>
<tr>
<td>National Oral Health Surveillance System</td>
<td>Requires that NOHSS include measurement of early childhood caries and authorizes funding to expand the system to all 50 states</td>
</tr>
</tbody>
</table>
ACA Pediatric Dental Benefit
Background: Pediatric Dental Benefit

- Insurance plans participating in an Exchange must provide, at a minimum, the “essential benefits package”

- [SEC 1302(b)] Essential Health Benefits “….the Secretary shall define the essential health benefit…(J) Pediatric services, including oral and vision care”

- Scope of benefits must be equivalent to the benefits provided under a “typical” employer-sponsored plan.
Background: Pediatric Dental Benefit

Essential benefits must be provided by:

- Qualified health plans (QHPs) and stand-alone dental plans participating in the Exchanges
- Health plans providing coverage in the small and individual group markets outside the Exchanges
- Basic health plans (for states that choose to establish)

- Bulletin issued by HHS on December 16, 2011
- FAQ released February 17, 2012
States are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange...

(1) the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
(2) any of the largest three State employee health benefit plans by enrollment;
(3) any of the largest three national FEHBP plan options by enrollment; or
(4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.
If a category is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer EHB. The State may select supplemental benefits from either:

1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or

2) The State’s separate CHIP program
## ACA EHB Benchmarks

<table>
<thead>
<tr>
<th>EHB Benchmark</th>
<th>Dental Offered</th>
<th>Child-Only Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) three largest <strong>small group insurance products</strong> in the State’s small group market</td>
<td>Not typically</td>
<td>No</td>
</tr>
<tr>
<td>(2) largest three <strong>State employee health benefit plans</strong> by enrollment</td>
<td>Varies</td>
<td>No</td>
</tr>
<tr>
<td>(3) largest three national <strong>FEHBP plan</strong> options by enrollment</td>
<td>Limited coverage</td>
<td>No</td>
</tr>
<tr>
<td>(4) largest insured <strong>commercial non-Medicaid HMO</strong> operating in the State</td>
<td>Varies</td>
<td>No</td>
</tr>
<tr>
<td>(5) <strong>FEDVIP</strong> dental plan with the largest national enrollment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(6) The State’s separate <strong>CHIP program</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Improving the Model of Pediatric Dental Coverage
Efforts to Improve Pediatric Dental Coverage

• Development of Consensus Statement w/ Delta Dental Plans Association
  "Federal regulators, in defining the pediatric benefit in ACA, should endorse a set of dental services that reflects current professional and governmental evidence-based guidelines and recommendations that are designed to improve oral health outcomes in children."

• Evidence based Guidelines and recommendations include:
  ✓ ADA Center for Evidence-Based Dentistry: recommendations on fluorides & dental sealants
  ✓ FDA-ADA: Guide to Patient Selection for Dental Radiographs
  ✓ AAPD policy: Model Dental Benefits for Infants, Children and Adolescents and Individuals with Special Care Needs
  ✓ AAP policy: Oral Health Risk Assessment Timing and Establishment of the Dental Home
  ✓ California Dental Assoc. guidelines: Caries Management by Risk Assessment
Consensus Statement

Recommendations predicated on 3 principles:

1. Effective and efficient dental care for children must be individualized according to their levels of disease risk and disease experience.

2. Existing clinical diagnostic and preventive resources should be directed so that the intensity of care received by children is tailored to their levels of disease risk and disease experience in collaboration with the child’s medical home and other community health care agencies.

3. All children should receive pediatric dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions for the attainment and maintenance of oral health.
Promoting the Risk-Based Benefit

- **January 2011:** CDHP asked to testify before IOM Panel on Essential Health Benefits
  - Promoting comprehensive risk-based, affordable benefit
- **September 2011:** Letters to Secretary Sebelius:
  - Letter from CDHP and 50+ signing organizations (including all Delta Dental Plans)
  - Letter from 42 Deans of 42 of the nation’s dental schools
- **2011:** Monitoring related Federal agency activity (DOL review of benefits, IOM recommendations, HHS regulations)
- **2011-2012:** Meetings with HHS, CMS, CCIOO, White House on benefit design, affordability, Exchange rules
Tracking CHIPRA Implementation: Improving the Benchmark
CHIP Dental Benefit

• **2009 Reauthorization (CHIPRA):** “services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.”
  – CHIP remains critical to ensuring comprehensive pediatric dental coverage
  – Authorized through 2019
  – Funding extended to 2016
  – Serves as a possible benchmark for ACA benefit
  – Opportunities exist for a risk-based approach
CHIP Dental Coverage

CHIP data taken from December 2011 report by **National Maternal & Child Oral Health Policy Center** and NASHP

- Review of 9 states with approved SPAs for CHIP dental benefit
- 7 of 9 States chose state-defined benefits (vs. benchmarks outline in 10/09 SHO letter)
- Significant variations in plans, including cost-sharing
- However, CHIP regulations for dental coverage have not been released (expected this year)
# CHIP Dental Benefits

**Iowa - hawk-I**  
(State Defined Benefit Package)

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Service</th>
<th>Cost</th>
<th>Cost-sharing</th>
<th>Out of Pocket Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Exam &amp; Cleaning</td>
<td>$300</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>1</td>
<td>X-Ray</td>
<td>$30</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>3</td>
<td>Filling</td>
<td>$300</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>1</td>
<td>Panoramic X-Ray</td>
<td>$100</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>1</td>
<td>Maxillary Expansion*</td>
<td>$2,000</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>2</td>
<td>Sedation</td>
<td>$100</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$2,830</td>
<td></td>
<td>$0</td>
</tr>
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<table>
<thead>
<tr>
<th>Annual Cap</th>
<th>Premium</th>
<th>Total 1 yr out of pocket by family</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

% of cost paid by family: 0%

% of cost w/ premium paid by family: 0%

*Orthodontics that meet the State’s definition of medically necessary are excluded from the annual cap.*
CHIP Dental Benefits

Montana - Healthy Montana Kids
(State Employees Benefits Plan)

<table>
<thead>
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<tbody>
<tr>
<td>2</td>
<td>Exam &amp; Cleaning</td>
<td>$300</td>
<td>0%</td>
<td>$0</td>
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<tr>
<td>1</td>
<td>X-Ray</td>
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<tr>
<td>3</td>
<td>Filling</td>
<td>$300</td>
<td>0%</td>
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<tr>
<td>1</td>
<td>Panoramic X-Ray</td>
<td>$100</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>1</td>
<td>Maxillary Expansion</td>
<td>$2,000</td>
<td>100%</td>
<td>$2,000</td>
</tr>
<tr>
<td>2</td>
<td>Sedation</td>
<td>$100</td>
<td>0%</td>
<td>$0</td>
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<tr>
<td></td>
<td><strong>Total</strong></td>
<td>$2,830</td>
<td></td>
<td>$2,000</td>
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<table>
<thead>
<tr>
<th>Annual Cap</th>
<th>Premium</th>
<th>Total 1 yr out of pocket by family</th>
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</thead>
<tbody>
<tr>
<td>$1,412</td>
<td>$0</td>
<td>$2,000</td>
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</table>

% of cost paid by family: 71%

% of cost w/ premium paid by family: 71%
### Tennessee - Cover Kids
(State Employee Benefits Plan)

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Service</th>
<th>Cost</th>
<th>Cost-sharing</th>
<th>Out of Pocket Cost (150% FPL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Exam &amp; Cleaning</td>
<td>$300</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>1</td>
<td>X-Ray</td>
<td>$30</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>3</td>
<td>Filling</td>
<td>$300</td>
<td>0%</td>
<td>$5/$25</td>
</tr>
<tr>
<td>1</td>
<td>Panoramic X-Ray</td>
<td>$100</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>1</td>
<td>Maxillary Expansion*</td>
<td>$2,000</td>
<td>0%</td>
<td>$5/$25</td>
</tr>
<tr>
<td>2</td>
<td>Sedation</td>
<td>$100</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$2,830</td>
<td></td>
<td>$10/$50</td>
</tr>
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</table>

**Annual Cap**

- **$1,000**
- **$0**

**Premium**

- **$0**

**Total 1 yr out of pocket by family**

- **$1,010/$1,050**

- 36%/37%

- % of cost paid by family

- % of cost w/ premium paid by family

*non-preventive visits: $5.00/visit 150% FPL and below to $15 annual max; $25.00/visit over 150% FPL to $75 annual max

*All orthodontics covered once enrolled for at least 12 months, up to benefit limit. Additional $1250 orthodontic lifetime cap.*
## CHIP Dental Benefits

### Nevada - Nevada Checkup
(State Defined Benefit Package)

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Service</th>
<th>Cost</th>
<th>Cost-sharing</th>
<th>Out of Pocket Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Exam &amp; Cleaning</td>
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<td>2</td>
<td>Sedation</td>
<td>$100</td>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$2,830</strong></td>
<td></td>
<td><strong>$0</strong></td>
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</tbody>
</table>

### Annual Cap

- **Premium**: $0
- **Total 1 yr out of pocket by family**: $0
- % of cost paid by family: 0%
- % of cost w/ premium paid by family: 0%

*Must be deemed medically necessary according to Nevada handicapping labiolingual deviation index.*
CDHP Recommendations

• CDHP Issue Brief: follow-up to study with NASHP

• Recommendations:
  – Clear and consistent guidance to states on benefit design and exclusions of services
  – Clear guidance and oversight on acceptable cost-sharing, financial benefit limits and tracking of medical and dental expenses
  – Encourage cost-effective risk-based pediatric dental benefits
Dental Plans in the Exchanges:
Promoting Affordability
Background: Dental Plans in the Exchanges

- Exchanges must permit stand-alone dental benefits to be offered either separately or in conjunction with a qualified health plan (QHP)
  - Although, QHPs do not have to offer dental if a stand alone offers pediatric coverage in the Exchange

- ACA uses HIPAA “excepted benefits” definition which includes stand-alone dental plans

- Stand-alone dental plans must provide the pediatric benefit in accordance with the requirements of the essential benefits package but...

- Prior to Exchange regulation, ACA treated stand-alones differently than traditional health plans with regard to cost sharing and consumer protections
What Might Have Been

Consistency and Parity in Benefits
Because stand-alone dental plans are statutorily excluded from consumer protections, there may be variation among the plans in the Exchange. For example, benefits provided by stand-alone dental plans are allowed to:

• charge for preventive services
• charge unlimited out-of-pocket expenses
• place annual and lifetime caps on benefits

Affordability
Because the cost-sharing reductions only apply to qualified health plans,
– Families may pay more in a stand-alone plan vs. QHP
– Families that opt out of dental coverage (and face no penalty) can apply their spending on pediatric dental care toward out-of-pocket limit
Promoting Affordability: The Controversy

• ACA gives states wide flexibility to enforce “relevant” consumer protections, certification standards, and affordability measures on dental plans in the Exchanges.

• Citing relevancy, many dental plans resisted state and federal applicability of many consumer protections, including:
  – Network adequacy standards
  – Cost-sharing reductions
  – Removal of annual and lifetime caps and limits
  – Mandatory external review of denied services
  – Quality improvement strategies and quality measures
Promoting Affordability: Advocacy Efforts

• **September 2011:** Senators Stabenow and Bingaman clarified relevancy and applicability of consumer protections through Colloquy on Senate floor.

• **October 2011:** Senate and House sign-on letters to Secretary Sebelius clarifying Congressional intent regarding dental plans and consumer protections and affordability.

• **October 2011:** CDHP & numerous state and national organizations responds to proposed rule on Exchanges and Qualified Health Plans, urging equal standards for dental plans and health plans.

• **December 2011:** Meetings with HHS and Administration officials to educate on the unintended consequences of not addressing these concerns.

• **2011-2012:** CDHP issues talking points, conducts webinars and intensive TA to states grappling with dental coverage in the Exchanges.
State Example: Maryland

• Addressing many of the consumer protection and cost-sharing issues through Exchange legislation (now addressed by Exchange rule).

• Maryland Dental Action Coalition (MDAC) and Advocates for Children & Youth (ACY) developed amendment language

• Worked with Maryland Legislature and Department of Health and Mental Hygiene and other stakeholders

• Reached consensus on language giving Exchange Board final authority on certification standards and benefit design.
Advocates’ Principles/Talking Points

• **Families may be forced to pay more and get less.** Applying consistent standards for cost, availability and consumer protections should be requirements to participate in the Exchange.

• **States have the ability to meet the oral health needs of children by promoting competition and choice.** Encouraging competition in dental coverage within the Exchange means playing by the same rules. Requiring transparency in benefits and pricing and the ability for all families to appeal the decision of their dental insurer are standards that promote competition while providing families the equal opportunities to stay healthy.

• **The law is complex, but the solution is simplification.** Applying the same certification standards to participate in the Exchange for stand-alone dental plans as is required for Qualified Health Plans for cost sharing and limits, child-only plans and external appeals is simply easier to administer than having separate standards for pediatric dental care.
Federal Outcome: Final Exchange Rule
HHS released final rule on Establishment of Exchanges and Qualified Health Plans on March 12, 2012. For dental plans, HHS plans to:

- impose cost-sharing limits and restrictions on annual and lifetime limits;
- require stand-alone dental plans to offer child-only plans in the Exchanges;
- require the Exchange to ensure that stand-alone dental possess the "solvency and provider network" to provide coverage;
- require that stand-alone dental plans comply with all certification standards for qualified health plans "except for those certification standards that cannot be met because the stand-alone dental plans covers only pediatric dental benefits;"
- direct the Exchanges to collect rate information on pediatric dental benefits for the purposes of determining advance payments of the premium tax credit;
Final Exchange Rule – March 2012

Implications:

• Traditional dental benefits like the benchmark plans will have to be significantly adjusted
• Dental plans can control for costs by focusing on medical necessity
• Risk-based benefit design may be a viable approach in light of restrictions on annual caps & lifetime limits
Ongoing Concerns:

• Network adequacy standards and quality measures have yet to be established for dental plans
• Dental plans are seeking exemption from actuarial value (metal levels)
• Insurers may pursue new cost-control measures (e.g., service limits, deductibles)
• Examples of risk-based pediatric dental benefit are not widely available in current insurance market
• Tracking out-of-pocket costs
Ongoing Efforts
Gathering Information

Model Risk-Based Plans:
- Consulting with experts on caries management and risk-based dental care (e.g. CAMBRA)
- Discussions with companies implementing similar benefits
- Discussions with insurers about developing new models

Actuarial Value:
- Collecting information on scope of services, treatment plans, etc.
- Estimating cost of plans to insurers and families
- Developing pricing estimates for model benefit plans for determination of EHB actuarial value
Advocacy

Federal Level:
• Discussions with CMS regarding CHIPRA regulations and option to provide risk-based benefit
• Memo to HHS officials regarding actuarial value and cost-control measures on dental plans in Exchanges

State Level:
• Educating advocates on issues of cost control and actuarial value
• Asking the right questions of Exchange, policymakers, and insurers
State Advocates: Opportunities for Action
Advocate Concerns

• Lack of specific guidance to States
  – CHIP is the only benchmark that provides a child-only benefit and it has yet to be defined

• Affordability for families to purchase dental coverage
  – Benefits offered by stand-alone dental plans should abide by the same rules as QHPs (largely addressed by Exchange rule)
  – Developing a mechanism for tracking out-of-pocket costs (dental and medical) for purpose of cost-sharing limits/reductions.

• Ability to meet the needs of children
  – Some states are requesting flexibility to provide evidence-based dental benefits for better outcomes and lower cost
Efforts Toward Improvement

- Asking HHS for further clarification on the dental benefit requirements of essential health benefits (EHB) and CHIPRA dental benefit.

- Asking HHS, State Officials, Exchange Board how they plan to enforce cost-sharing limits.

- Asking dental insurers about innovative risk-based plans to be made available on the Exchange.

- Speaking up for strong certification standards to participate in the Exchange that allow for parity among dental benefits offered (e.g., network adequacy standards, quality improvement, quality measures).

- Research current state benchmark plans, including the details of CHIP dental benefit, to inform decisions on the benefit design.
Other Dental Benefit Concerns

- **Premium Tax Credit:** Fixing the “Family Glitch” in the affordability test for employer-sponsored health insurance to ensure that affordability is based on cost of family coverage.

- **Uniform Summary of Benefits:** defined to apply to all dental benefits.

- **Ensuring smooth transition** and comparable benefits for children moving between Medicaid, CHIP, and Exchanges.

- **Actuarial Value:** How will it be calculated for dental?
Where are Other States?

Source: www.kidswellcampaign.org
Resources

• CDHP Health Reform Center
  www.cdhp.org/cdhp_healthcare_reform_center

• National Maternal & Child Oral Health Policy Center
  www.nmcohp.org

...or contact us!

Colin Reusch
creusch@cdhp.org
202-417-3595
Update on Oral Health Provisions in The Affordable Care Act: Controversies and Actions Taken

May 2, 2012
National Oral Health Conference

Burton Edelstein DDS MPH
Children’s Dental Health Project
A report to oral health advocates

From
Down-in-the Weeds
where the action is
Affordable Care Act and Oral Health

23 ACA provisions provide a comprehensive structure to address oral health & dental care

<table>
<thead>
<tr>
<th>Prevention &amp; Health Promotion</th>
<th>Quality Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Health Infrastructure &amp; Capacity</td>
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<tr>
<td>Community Awareness/Education</td>
<td>Effective Coverage</td>
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<tr>
<td>Family-level Prevention</td>
<td>Effective Workforce</td>
</tr>
<tr>
<td>Child-level disease management</td>
<td>Effective Delivery Systems</td>
</tr>
<tr>
<td>Surveillance, Evaluation, CQI</td>
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Status of ACA Oral Health Provisions

Coverage & Financing

Regulatory action underway...

– Pediatric dental benefit
– Standalone dental plans in Exchanges

No action yet

– CHIP maintenance to 2019
– MACPAC review of dental rates in Medicaid/CHIP
– Medicaid expansions in 2014 – In litigation at Supreme Court
Status of ACA Oral Health Provisions

Prevention

Funded
– Prevention and Public Health Trust Fund
– Community transformation grants

Unfunded
– Caries management demonstrations
– School sealant program expansions
– Oral health public education campaign
– National prevention, health promotion public health council
Status of ACA Oral Health Provisions

Workforce & Training

Funded
- Dental training programs (aka “Title VII”)
- Community transformation grants

Unfunded
- Alternative provider demonstrations (with one exception in MN)
- National Health Care Workforce Commission
- Primary care residency program expansions
- Graduate Medical Education expansions
Status of ACA Oral Health Provisions

Delivery System

Funded

– Federally Qualified Health Center expansions
– School Based Health Care expansions
Status of ACA Oral Health Provisions

Surveillance & Infrastructure

Funded
  – State Oral Health Infrastructure Grants (now 20 states)

Unfunded
  – Oral health survey enhancements
    • PRAMS
    • NHANES
    • MEPS
    • NOHSS
ACA Pediatric Dental Benefit: Controversy and Action
Background: Pediatric Dental Benefit

Controversies:

• Children’s dental coverage is an “essential health benefit” but what does it look like?
  – Law requires equivalence with “typical employer plan”
    But child-only employer plans are rare
  – Law requires equivalence with a “benchmark plan”
    But the only suitable benchmark is CHIP
  – Law fines those who don’t purchase qualified health plans
    But does not fine those who don’t buy separate dental coverage
  – Law allows Qualified Health Plans to offer dental
    But few medical plans do so
  – Law caps out-of-pocket expenses
    But how can they be tracked across all OOPs
Designing the Pediatric Dental Benefit

Challenge: To apply public health, public policy, and accountability principles to the dental benefit design

- Most efficient allocation of limited resources
- Prevention focused
- Based on best use of science
- Geared to best health outcomes at lowest cost

Consensus Statement

“Federal regulators, in defining the pediatric benefit in ACA, should endorse a set of dental services that reflects current professional and governmental evidence-based guidelines and recommendations that are designed to improve oral health outcomes in children.”
Efforts to Improve Pediatric Dental Coverage

Guideline are based on:

- ADA for evidence based fluorides & sealants
- FDA-ADA for radiographs
- AAPD for tiered care by risk
- AAP for early intervention and care coordination
- California Dental Association for CAMBRA

Goal is modern, comprehensive care consistent with CHIP Benchmark

“Pediatric dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions for the attainment and maintenance of oral health.”
Actions to Promote the Risk-Based Benefit

• IOM testimony
• Sign on letters to HHS Secretary
  – CDHP and 50+ organizations
  – 42 dental school deans
• Monitoring and commenting on Federal agency activity
  – Department of Labor review
  – IOM recommendations
  – HHS regulations
• Meetings with HHS, CMS, CCIIO, and the White House on benefit design, affordability, Exchange rules
Assuring Affordability of Dental Plans in the Exchanges: Controversies and Actions
**Background: Dental Plans in the Exchanges**

Controversy: ACA’s reference to standalone dental plans creates confusion over applicability of consumer protections including

- Network adequacy standards
- Cost-sharing reductions
- Prohibition of annual and lifetime caps and limits
- Mandatory external review of denied services
- Quality improvement strategies and quality measures

However, ACA explicitly requires that standalone plans comply with “relevant consumer protections”
Action Taken to assure Consumer protections in dental plans

- Senate colloquy
- Senate and House sign-on letters re Congressional intent
- Response to proposed rules
- Meetings with HHS officials to educate on potential unintended consequences
- Information dissemination
  - talking points
  - webinars
  - intensive technical assistance to states grappling with dental coverage in the Exchanges
HHS final rule on Exchanges and Qualified Health Plans on March 12, 2012.

For dental plans, HHS will

- Require child-only plans
- Disallow annual and lifetime limits
- Impose cost-sharing limits
- Require plans to show "solvency and provider network"
- Require that plans comply with all certification standards "except [those] that cannot be met because the standalone dental plans cover only pediatric dental benefits"
- Direct Exchanges to collect rate information on pediatric dental benefits
Implications

- Traditional dental plans will require some redesign
- Dental plans may need to control costs through medical necessity
- Risk-based benefit design may be an attractive design in light of limits on annual & lifetime caps
Next Concerns

– Network adequacy standards
– Quality measures
– Actuarial value
– Tracking aggregate out-of-pocket costs
– Alternative care restriction approaches
– Learning from pediatric commercial plans
Working together

The Children’s Dental Health Project

– Continues to promote risk-based benefit design and affordability with regulators
– Tracks and responds as appropriate to legislative, regulatory, and judicial action
– Provides information to state-level oral health advocates
  • Web at www.cdhp.org
  • Webinars
  • Publications
  • Technical assistance
– Looks to you to promote modern, meaningful, and affordable dental coverage across the states for the 7.8 million children who will become eligible for coverage in 2014
CDHP Resources

• Visit
  – CDHP Health Reform Center: [www.cdhp.org](http://www.cdhp.org) Click on “Health Reform Center”

• Contact CDHP’s

  Colin Reusch
  creusch@cdhp.org
  202/833-8288

  Meg Booth
  mbooth@cdhp.org
  202/833-8288