Oral Health Provisions in The Affordable Care Act: Controversies and Actions Taken

April 29, 2012

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ACA and Oral Health

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

Dental Caries Disease Management	Establishes a national grant program to demonstrate the effectiveness of research-based dental caries disease management
School-based Dental Sealant Programs	Requires that states receive grants for school-based dental sealant programs
Oral Health Public Education Campaign	Requires HHS Secretary to establish a 5-year public education campaign to promote oral health
Prevention and Public Health Trust Fund	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.
National Prevention, Health Promotion, and Public Health Council	Charged with coordinating Federal prevention policy and developing a national prevention strategic plan
Community Transformation Grants	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 & 2012

Effective Coverage

★ **Oral Health Services for Children**	Requires State Exchanges to include oral health services to children as part of the Essential Health Benefits Package
Stand-Alone Dental Plans	Allows stand-alone dental plans with pediatric benefits to participate in State Exchanges
MACPAC Reporting on Dental Payments	Requires MACPAC to review payments to dental professionals and report to Congress: $9 million for FY 2010 to remain available until expended
CHIP Maintenance	Funding made available through FY 2015 – increased federal assistance in FY 2016 , CHIP maintained until 2019
Medicaid Expansion	Expands Medicaid coverage to individuals whose income is 133% of FPL or less.

Workforce and Training

Alternative Dental Health Care Providers	Establishes a 15-site demonstration project to train or employ alternative dental health care professionals
National Health Care Workforce Commission	Establishes the Commission and makes the oral health care workforce a high priority for review
Dental Training Programs	SEC 5303 - General, pediatric, and public health dentistry training program funded at $30 million for FY 2010.
Primary Care Residency Programs	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.
Graduate Medical Education Programs	Provides funding for new and expanded graduate medical education, including dental education

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

Oral Health Infrastructure	Requires the CDC to provide cooperative agreements to states for improving oral health infrastructure (from 19 states →50 states, territories, & tribes)
Pregnancy Risk Assessment and Monitoring System	Requires that oral health measurements be included in PRAMS
National Health and Nutrition Examination Survey	Retains "tooth-level" surveillance in NHANES
Medical Expenditure Panel	Requires a "look-back" validation for dental - parity with medical
National Oral Health Surveillance System	Requires that NOHSS include measurement of early childhood caries and authorizes funding to expand the system to all 50 states

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

EHB Bulletin – December 2011

*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.

EHB Bulletin

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

EHB Benchmark	Dental Offered	Child-Only Benefit
(1) three largest **small group insurance products** in the State's small group market	Not typically	No
(2) largest three **State employee health benefit plans** by enrollment	Varies	No
(3) largest three national **FEHBP plan** options by enrollment	Limited coverage	No
(4) largest insured **commercial non-Medicaid HMO** operating in the State	Varies	No
(5) **FEDVIP** dental plan with the largest national enrollment	**Yes**	No
(6) The State's separate **CHIP program**	**Yes**	**Yes**

Improving the Model of Pediatric Dental Coverage

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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

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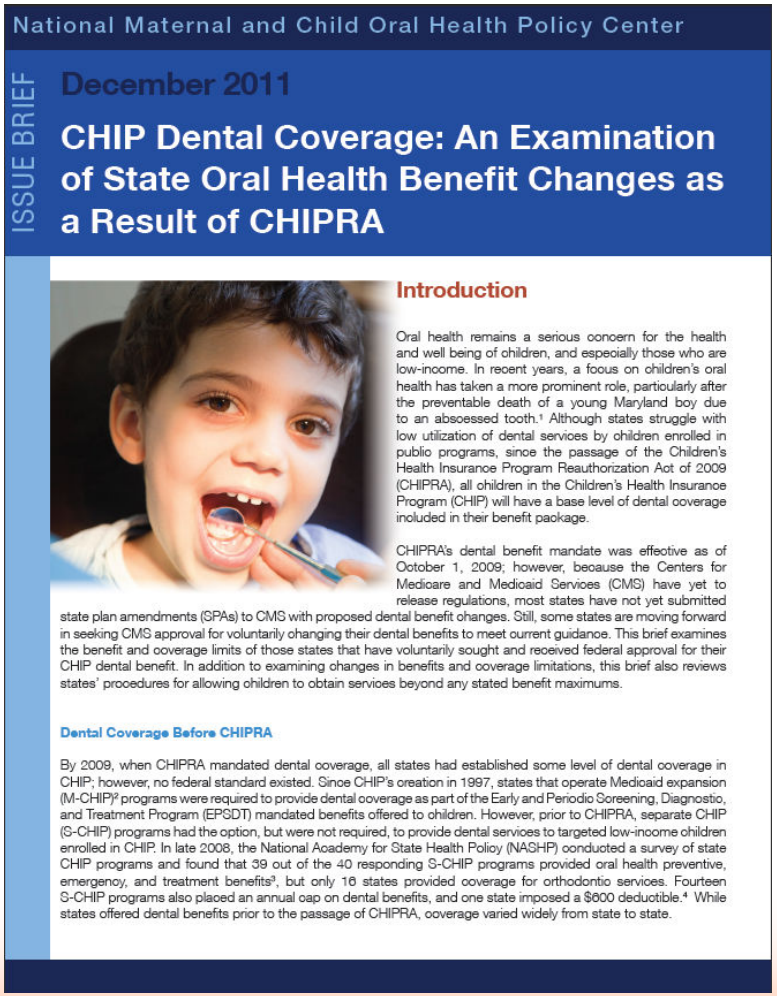
CHIP Dental Benefit

- **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)



National Maternal and Child Oral Health Policy Center

ISSUE BRIEF

December 2011

CHIP Dental Coverage: An Examination of State Oral Health Benefit Changes as a Result of CHIPRA

Oral health remains a serious concern for the health and well being of children, and especially those who are low-income. In recent years, a focus on children's oral health has taken a more prominent role, particularly after the preventable death of a young Maryland boy due to an abscessed tooth.[1] Although states struggle with low utilization of dental services by children enrolled in public programs, since the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), all children in the Children's Health Insurance Program (CHIP) will have a base level of dental coverage included in their benefit package.

CHIPRA's dental benefit mandate was effective as of October 1, 2009; however, because the Centers for Medicare and Medicaid Services (CMS) have yet to release regulations, most states have not yet submitted state plan amendments (SPAs) to CMS with proposed dental benefit changes. Still, some states are moving forward in seeking CMS approval for voluntarily changing their dental benefits to meet current guidance. This brief examines the benefit and coverage limits of those states that have voluntarily sought and received federal approval for their CHIP dental benefit. In addition to examining changes in benefits and coverage limitations, this brief also reviews states' procedures for allowing children to obtain services beyond any stated benefit maximums.

Dental Coverage Before CHIPRA

By 2009, when CHIPRA mandated dental coverage, all states had established some level of dental coverage in CHIP; however, no federal standard existed. Since CHIP's creation in 1997, states that operate Medicaid expansion (M-CHIP)[2] programs were required to provide dental coverage as part of the Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) mandated benefits offered to children. However, prior to CHIPRA, separate CHIP (S-CHIP) programs had the option, but were not required, to provide dental services to targeted low-income children enrolled in CHIP. In late 2008, the National Academy for State Health Policy (NASHP) conducted a survey of state CHIP programs and found that 39 out of the 40 responding S-CHIP programs provided oral health preventive, emergency, and treatment benefits[3], but only 16 states provided coverage for orthodontic services. Fourteen S-CHIP programs also placed an annual cap on dental benefits, and one state imposed a $600 deductible.[4] While states offered dental benefits prior to the passage of CHIPRA, coverage varied widely from state to state.

CHIP Dental Benefits

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

Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	$300	0%	$0
1	X-Ray	$30	0%	$0
3	Filling	$300	0%	$0
1	Panoramic X-Ray	$100	0%	$0
1	Maxillary Expansion*	$2,000	0%	$0
2	Sedation	$100	0%	$0
Total		$2,830		$0

Annual Cap	Premium	Total 1 yr out of pocket by family
$1,000	$0	**$0**
	% 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)

Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	$300	0%	$0
1	X-Ray	$30	0%	$0
3	Filling	$300	0%	$0
1	Panoramic X-Ray	$100	0%	$0
1	Maxillary Expansion	$2,000	100%	$2,000
2	Sedation	$100	0%	$0
Total		$2,830		$2,000

Annual Cap	Premium	Total 1 yr out of pocket by family
$1,412	$0	**$2,000**
	% of cost paid by family	71%
	% of cost w/ premium paid by family	71%

CHIP Dental Benefits

Tennessee - Cover Kids
(State Employee Benefits Plan)

Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost (<150% FPL/>150% FPL)
2	Exam & Cleaning	$300	0%	$0
1	X-Ray	$30	0%	$0
3	Filling	$300	0%	$5/$25∞
1	Panoramic X-Ray	$100	0%	$0
1	Maxillary Expansion*	$2,000	0%	$5/$25∞
2	Sedation	$100	0%	$0
Total		$2,830		$10/$50 ∞
	Annual Cap	**Premium**		**Total 1 yr out of pocket by family**
				$1,010/$1,050
	*$1,000	$0		
				36%/37%
		% of cost paid by family		
		% of cost w/ premium paid by family		36%/37%

∞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)

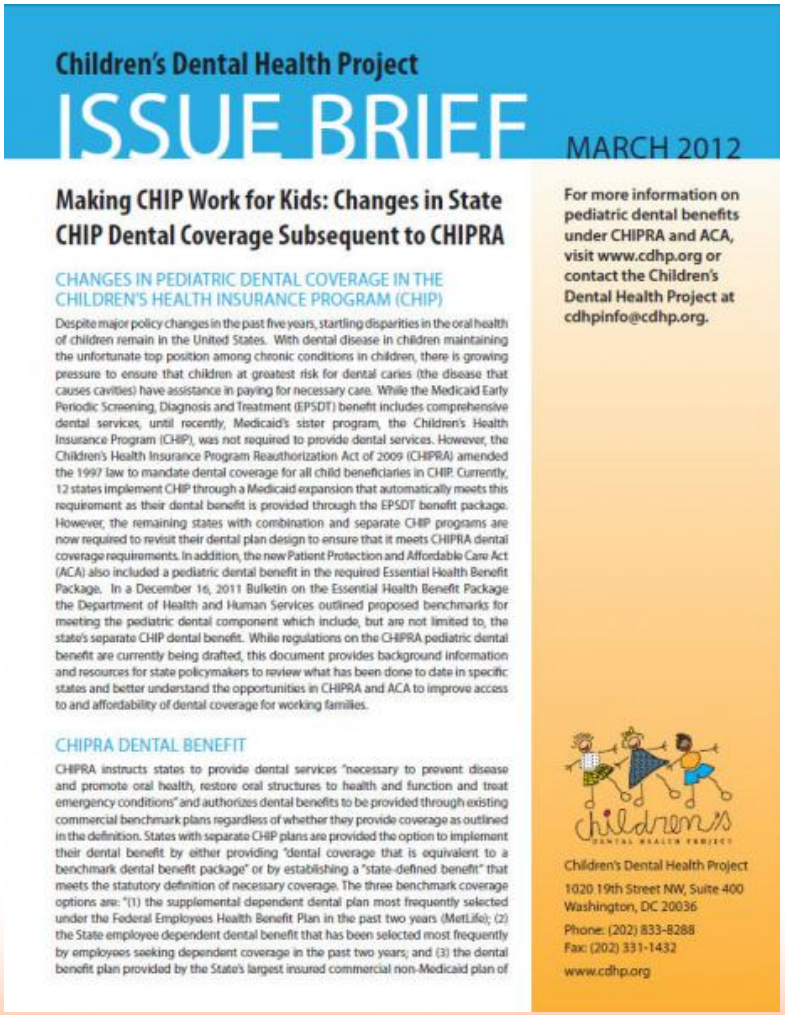
Quantity	Service	Cost	Cost-sharing	Out of Pocket Cost
2	Exam & Cleaning	$300	0%	$0
1	X-Ray	$30	0%	$0
3	Filling	$300	0%	$0
1	Panoramic X-Ray	$100	0%	$0
1	Maxillary Expansion*	$2,000	0%	$0
2	Sedation	$100	0%	$0
Total		$2,830		$0

Annual Cap	Premium	Total 1 yr out of pocket by family
none	$0	**$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**



Children's Dental Health Project

ISSUE BRIEF MARCH 2012

Making CHIP Work for Kids: Changes in State CHIP Dental Coverage Subsequent to CHIPRA

CHANGES IN PEDIATRIC DENTAL COVERAGE IN THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Despite major policy changes in the past five years, startling disparities in the oral health of children remain in the United States. With dental disease in children maintaining the unfortunate top position among chronic conditions in children, there is growing pressure to ensure that children at greatest risk for dental caries (the disease that causes cavities) have assistance in paying for necessary care. While the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit includes comprehensive dental services, until recently, Medicaid's sister program, the Children's Health Insurance Program (CHIP), was not required to provide dental services. However, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended the 1997 law to mandate dental coverage for all child beneficiaries in CHIP. Currently, 12 states implement CHIP through a Medicaid expansion that automatically meets this requirement as their dental benefit is provided through the EPSDT benefit package. However, the remaining states with combination and separate CHIP programs are now required to revisit their dental plan design to ensure that it meets CHIPRA dental coverage requirements. In addition, the new Patient Protection and Affordable Care Act (ACA) also included a pediatric dental benefit in the required Essential Health Benefit Package. In a December 16, 2011 Bulletin on the Essential Health Benefit Package the Department of Health and Human Services outlined proposed benchmarks for meeting the pediatric dental component which include, but are not limited to, the state's separate CHIP dental benefit. While regulations on the CHIPRA pediatric dental benefit are currently being drafted, this document provides background information and resources for state policymakers to review what has been done to date in specific states and better understand the opportunities in CHIPRA and ACA to improve access to and affordability of dental coverage for working families.

CHIPRA DENTAL BENEFIT

CHIPRA instructs states to provide dental services "necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions" and authorizes dental benefits to be provided through existing commercial benchmark plans regardless of whether they provide coverage as outlined in the definition. States with separate CHIP plans are provided the option to implement their dental benefit by either providing "dental coverage that is equivalent to a benchmark dental benefit package" or by establishing a "state-defined benefit" that meets the statutory definition of necessary coverage. The three benchmark coverage options are: "(1) the supplemental dependent dental plan most frequently selected under the Federal Employees Health Benefit Plan in the past two years (MetLife); (2) the State employee dependent dental benefit that has been selected most frequently by employees seeking dependent coverage in the past two years; and (3) the dental benefit plan provided by the State's largest insured commercial non-Medicaid plan of

For more information on pediatric dental benefits under CHIPRA and ACA, visit www.cdhp.org or contact the Children's Dental Health Project at cdhpinfo@cdhp.org.

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Dental Plans in the Exchanges: Promoting Affordability

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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

Final Exchange Rule – March 2012

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 posess 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

Final Exchange Rule – March 2012

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

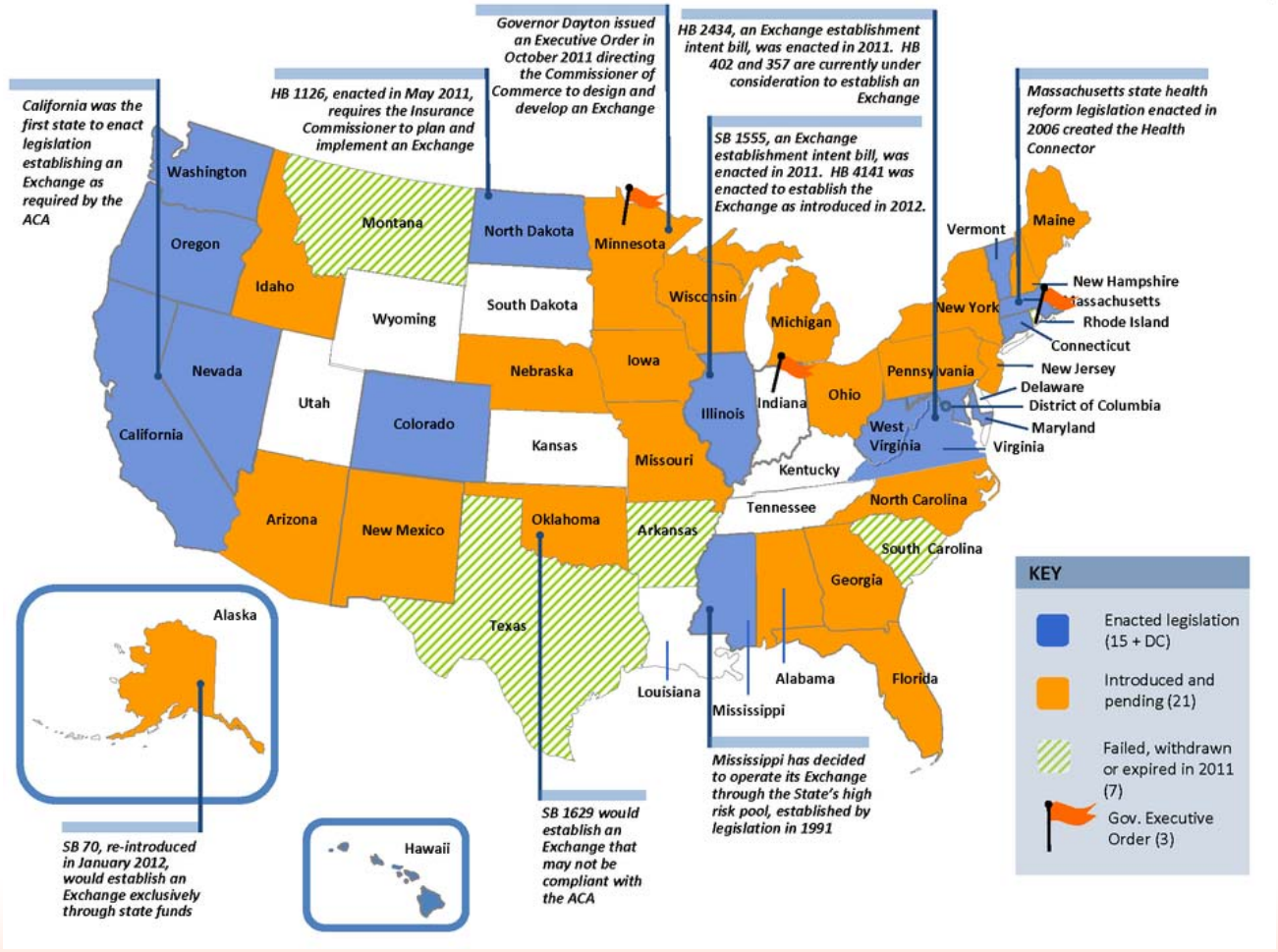
- **Premium Tax Credit:** Fixing the "Family Glitch" in the affordability test for employer-sponsored health insurance to ensure that affordability is based on cost of family coverage

- **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.nmcohpc.org

…or contact us!

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