

A Roadmap for Implementation, Part II: Dental Care Provisions in Health Reform

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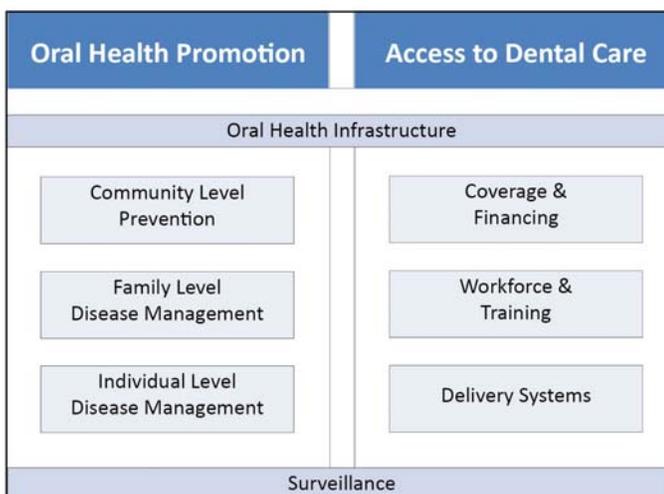


Purpose of this whitepaper

Dental care is essential to obtaining and maintaining oral health. It contributes to preventing oral diseases and conditions. When prevention fails, it is critical for repairing damage done by the two most common oral diseases—dental caries (tooth decay) and periodontal disease (gum disease). Dentists and the dental team also address oral cancer, traumatic injuries, developmental disturbances, problems with the bite, and pathologies associated with the soft lining of the mouth and the temporomandibular joint (TMJ).

In addition to access to dental care, oral health is obtained and maintained through positive health behaviors, favorable genetics, and a salutary environment that includes fluoridation and support of healthful eating. These components are reflected in the left side of the figure below and are thoroughly explored in a companion document, *Moving on the Oral Health Provisions in Health Reform: A Roadmap for Implementation*. That document clarifies the underlying oral health issues that ACA addresses and puts many of the dental provisions within the contexts of a public information campaign and integration of oral health into other health promotion activities, advancement of science-based prevention, workforce enhancements including alternative providers who supervise disease management and care coordination, dental sealants, and oral health surveillance.

This brief addresses the right side of the figure and deals with the many ways that ACA seeks to improve dental care as a key approach to improving oral health. It clarifies why dental care and dental coverage are important, how Medicaid, CHIPRA, and ACA work together to provide extensive dental coverage for children (but not for adults), and how ACA improves workforce and training, expands the safety net, addresses payment issues for providers, and supports dental public health activities in the states.



The Patient Protection and Affordable Care Act (ACA) is fundamentally a coverage act. Its central purpose is to assure access to affordable, stable health insurance for those who currently lack coverage. The Congressional Budget Office estimates that 16 million individuals—primarily poor adults who are poor or low-income but have not qualified under one of the “categorical” eligibility standards (e.g. pregnant women, mothers, disabled)—will gain coverage through Medicaid and an additional 16 million Americans will gain coverage through private insurance offered in state-level Exchanges or through employers. The law establishes a minimum set of required benefits that includes pediatric dental coverage but not adult dental coverage. For preventive services, it references standards established by the federal Guide to Community Preventive Services.¹ For children it goes further and references standards established by authorities like Bright Futures, a consensus resource for professionals and families in supervising child growth, development, and health.²

The law recognizes that coverage alone cannot assure access to effective dental care. ACA therefore additionally prioritizes dental workforce and training, the adequacy of the dental safety net, payments

to dental providers, and state oral health infrastructure that supports dental care delivery. These provisions translate coverage into care. They, together with recommended action steps to secure their effective implementation, are explored through this whitepaper.

- ***Why dental care matters***

As with general health, opportunities for good oral health depend largely on our social, environmental, behavioral, and genetic attributes. Yet primary dental care is itself an important contributor to positive oral health³— whether for repair when needed or for reliable information and motivation to encourage preventive care at home. Regular clinical evaluation by a dental professional is particularly important because the three major oral diseases—caries, periodontal disease, and oral cancer—are all symptom-free until very advanced, highly destructive, and irreversible. Additionally, most people require regular cleanings to maintain periodontal health that is so essential to tooth retention.

Ongoing professional dental care that begins at age one is promoted by American Academy of Pediatrics (AAP), American Academy of Pediatric Dentistry (AAPD), and Bright Futures as essential for early risk identification, anticipatory guidance, primary prevention, and disease management. National Institutes of Health (IOM) similarly advises parents to seek regular dental care early in their children’s lives⁴ based on its extensive portfolio of caries studies including ongoing studies that hold promise to reduce disparities.⁵ Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) instituted a requirement that parents of newborns whose birth services are funded by Medicaid and CHIP must be provided with information about caries prevention and the appropriateness of an age-one dental visit. Each of these efforts highlights the important role of professional preventive dental care in reducing disease incidence.

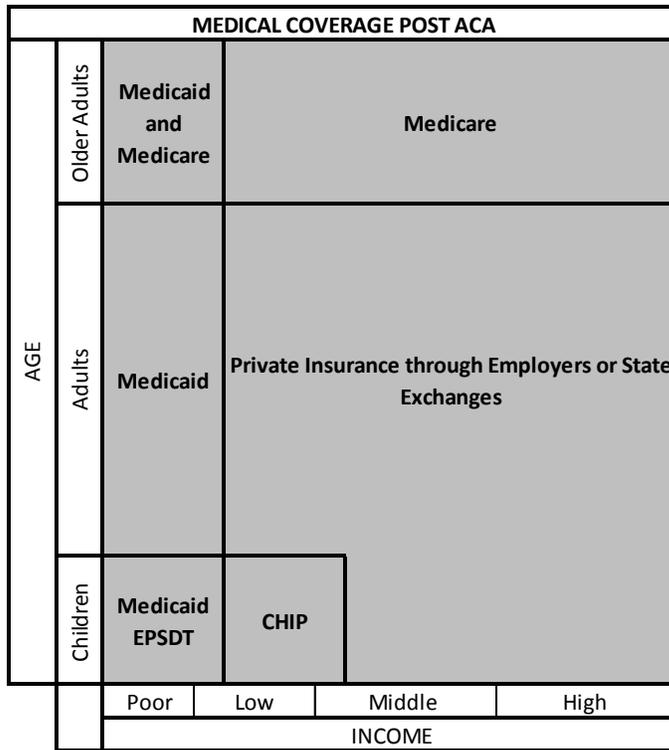
The dental home concept—defined by AAPD as “the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way”⁶—has been widely endorsed by Head Start, health professional organizations, Bright Futures, and federal agencies. However, significant implementation barriers including limitations in systems capacity⁷ have lead Congress to fund a demonstration in Iowa’s Medicaid program that uses a multidisciplinary team approach that is not exclusive to dentists. The team additionally includes specially prepared physicians, nurse practitioners, nurses, physician assistants and dietitians in a network that provides oral screenings, education, anticipatory guidance and preventive services as needed.⁸ Such “usual sources of care” are important as children without such a source are 1.63 times more likely to have an unmet need for care than children with a source of primary dental care.⁹

In defining primary care, the IOM recognized the complex interplay between clinical care and the larger contexts of family and community by advocating for systems that support a “sustained partnership” between the patient and a clinician.¹⁰ The Agency for Healthcare Research and Quality (AHRQ) expands on these attributes by calling for primary care that is “effective, efficient, timely, safe, patient centered, and equitable.” Because of the historical separation of medicine and dentistry in the US, the dental delivery system is typically regarded as though it were independent of the medical delivery system rather than a specialty service, yet these primary care characteristics matter as much to dental care as to medical care.

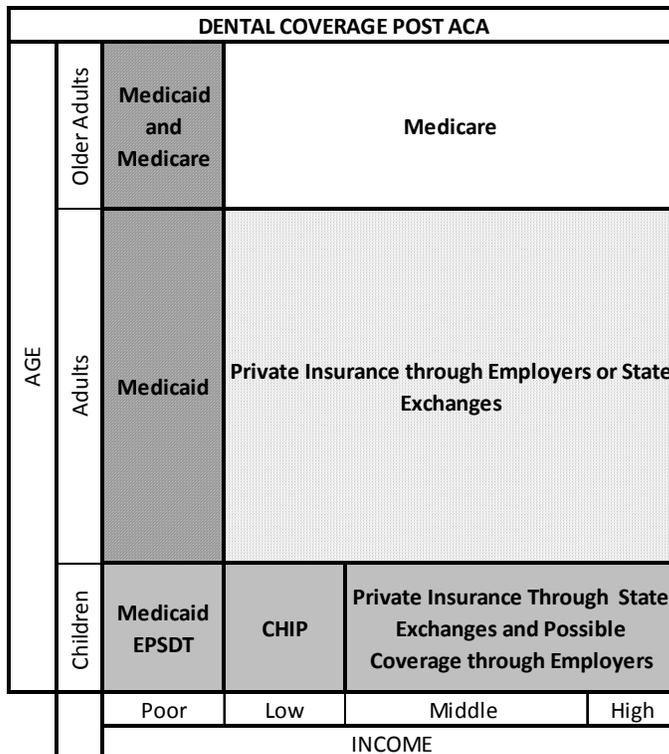
Bridging the medical-dental delivery systems divide remains a challenge despite growing public and professional awareness of oral-systemic health connections and the value of dental care in managing

other chronic conditions. The professions' separation is reinforced by parallel but independent educational systems, licensing authorities, payment mechanisms, "mid-level" providers, and professional organizations. Nonetheless, the US Preventive Health Services Task Force recognizes the importance of physicians and nurses in preventing dental and periodontal disease¹¹ and raises the possibility of physicians' and nurses' roles in promoting children's oral health.¹² Various efforts have been made to more closely link medical and dental care particularly for young children who see physicians more often than dentists during the critical infancy and toddler years when caries is established. Medicaid programs in all but 10 states allow reimbursement to physicians for oral health screenings and fluoride varnish applications¹³ and CMS is now expanding its monitoring of dental services to include those provided by medical personnel. Examples of additional medical-dental collaborations include collocation as in Federally Qualified Health Centers; co-development of programs as in the HRSA-sponsored Interfaces Project;¹⁴ education as in initiatives by pediatric¹⁵ and family physician organizations;¹⁶ payment incentives as in a New Jersey AmeriChoice program that incentivizes primary care physicians to provide counseling, risk assessment, preventive services, and completed referrals to dentists; and State level oral health action as in the North Carolina *Into the Mouths of Babes* program.¹⁷ ACA furthers medical-dental cooperation by incentivizing faculty loan repayments that "propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry" (Section 748(c)(1)).

The following figures compare medical with dental coverage subsequent to establishment of the State Exchanges as of January 1, 2014. Notably, while medical coverage is universal, dental coverage remains unavailable to older adults through Medicare (white boxes) or to those working age adults whose employers do not offer dental coverage (dotted boxes). Since adult dental benefits in Medicaid remain a state option, poor and low-income adults will be able to access dental coverage through Medicaid only if their state elects such coverage (slashed boxes). States will continue to vary significantly in the quality and quantity of adult Medicaid coverage—from none to reasonably comprehensive. Children across the income spectrum will have access to coverage through Medicaid for the poor, CHIP for the working poor, employer coverage and State Exchanges for higher income children.



 Mandatory medical coverage



 No dental coverage

 Optional dental coverage

 Variable dental coverage

 Mandatory dental coverage

- **Dental Coverage in the US**

ACA is most centrally an Act to increase health insurance coverage. While it focuses on medical coverage, it extends dental coverage to children. Medical and dental coverage each significantly and independently impact the use of dental services. Nearly half of all US residents of all ages (44%)¹⁸ obtain at least one dental visit in a year. More than twice as many adults with no *medical* insurance delay dental care because of cost than do adults who have employer sponsored medical coverage (47% versus 17%).¹⁹ Having *dental* coverage doubles the likelihood of having a dental visit in a year (Table).²⁰

Percent US Population with a Dental Visit in a Year: Impact of Dental Insurance				
	All	Private Dental Insurance (54% of US population)	Public Dental Insurance (12% of US population)	No Dental Insurance (35% of US population)
Children	45%	58%	34%	28%
Working age adults	43%	56%	28%	22%
Seniors	43%	65%	26%	37%
Total Population	44%	57%	32%	27%

For children, ACA builds on federal precedent to address many who remain without dental coverage. As a result of Medicaid EPSDT, CHIPRA and ACA—all of which mandate child dental benefits—the vast majority of US children will have access to public or private dental coverage after the Exchanges begin in 2014.

		Medicaid	CHIP	ACA	Employer
Child	Medical	yes	yes	yes	Employer option <ul style="list-style-type: none"> • If dependent medical is not offered by the employer, child medical coverage is available from <ul style="list-style-type: none"> - Medicaid - CHIP, or - ACA depending on family income
	Dental	yes	yes	yes	Employer option <ul style="list-style-type: none"> • If dependent dental is not offered by the employer, child dental coverage is available <ul style="list-style-type: none"> - from Medicaid if income eligible - from CHIP if income eligible but only in states that elect the CHIP “supplemental dental” option. - yet undetermined is whether families with incomes higher than Medicaid and CHIP eligibility can seek dental-only coverage for children in the ACA Exchanges
Adult	Medical	yes	yes	yes	Employer option <ul style="list-style-type: none"> • If adult medical is not offered by

					the employer, medical coverage is available from - Medicaid or - ACA depending on family income
	Dental	state option	n/a	no	Employer option • If adult dental is not offered by the employer, dental coverage may be available Medicaid if income eligible and state opts to provide an adult dental benefit

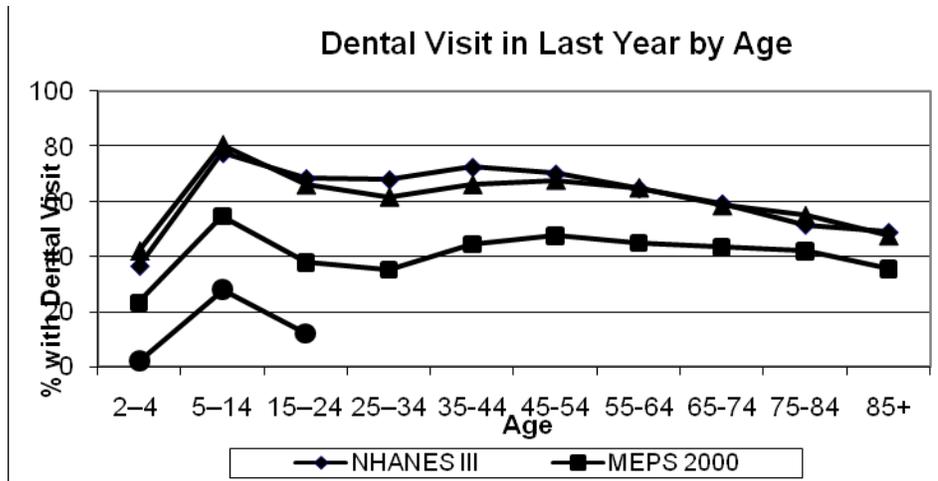
Most large employers offer both employee and dependent dental coverage. Employers who do not may begin doing so under the normative influence of the Exchange plans.

• **The nature of dental coverage**

Dental insurance has evolved predominately as limited-scope benefit plans offered to employers as an independent product, either by companies that also sell medical plans or by independent dental plans (some of which also offer vision coverage). Although plans that offer combined medical and dental coverage, the benefits are typically managed internally as two independent products. ACA addressed the limited-scope dental plans by explicitly authorizing their participation in the Exchanges “either separately or in conjunction with a qualified health plan” (Section 1302(b)(1)(J)). While cost sharing for preventive services, including dental preventive services, are prohibited (Section 1001), limited-scope dental plans may be exempted from additional cost-sharing protections that apply to medical plans (Section 1402(c)(5)).

• **Disparities in dental care**

As with medical care, the use of dental care is not evenly distributed across the American population. At all ages, income is the best predictor of dental services with about twice as many high income Americans obtaining at least one dental visit in a year (58%) compared to poor and low-income individuals (27% and 30% respectively).²¹ Similarly, those with private dental coverage are about twice as likely to have a dental visit (57%) as Americans with public dental coverage or no dental coverage (32% and 27% respectively). Use of dental services varies by age (Figure below) with peak use during childhood and early adolescence and a second upturn in middle age. All federal surveys show the same pattern of dental use but differ in degree. MEPS (see line with square markers) is regarded as the most reliable, if somewhat understated, while self-reported findings from the National Health Interview Survey (triangle markers) and National Health and Nutrition Examination Survey (diamond markers) tend to overstate use.²² Additional information on children’s use is available from the National Survey of Children’s Health which reports even higher parental estimates of use (49% for children ages 1-5; 85% for children ages 6-11; and 81% for children 12-17).²³ Use of services by poor and low-income children and adolescents in Medicaid (circle markers) has been considerably less than for the population at large.



Among children, correlates of failure to receive preventive dental care include immigrant status, single parent family, less than high school education of parent(s), being low income, having parents in poor general health, and having public insurance.²⁴

ACA’s Strategies to Improve Dental Care in America

ACA seeks to ensure that adequacy, and promote equity, of dental care in the US by focusing on care delivery’s core components: coverage, workforce, safety net, payment, and state oral health program infrastructure.

- **Dental coverage**

A central mode ACA addresses oral health is through the inclusion of dental benefits as integral to the required pediatric coverage. However, the quality of the mandated pediatric dental benefit in ACA remains unresolved. If the dental benefit is designed to reflect dental coverage in existing public programs, it will be sufficiently comprehensive and robust to meet children’s needs. Medicaid’s EPSDT sets the highest standard by ensuring that services prescribed by a licensed dental professional are covered. CHIPRA defines the dental benefit as including services “necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.” As yet undetermined are the specific standards that will meet ACA law as it states only that the essential health benefits package provides “pediatric services, including oral and vision care.” Pediatric dental benefits in ACA need to be designed to meet the needs of children, while establishing affordable and accessible coverage.

Actions needed:

1. Advocacy. Child advocates need to strongly encourage the regulations developed for the Exchanges define the pediatric dental benefit based on dental necessity.
2. Congressional Oversight. Congress must monitor federal and state implementation of the Exchanges to ensure the pediatric benefits meets Congressional intent of providing comprehensive pediatric coverage, including oral health services.
3. Definition of Benefit. The current Institute of Medicine Committee on Oral Health Access to Services needs to promote a strong definition of the pediatric dental benefit in ACA and provision of the dental supplement as fundamental determinants of access.

- **Public dental coverage**

Medicaid and CHIP remains and will continue to provide coverage to a significant proportion of children seeking dental care. ACA included the stipulation of accepting Medicaid funding; states are required to maintain their eligibility and enrollment standards as were in effect as of enactment of ACA until January 1, 2014 and expand minimum coverage for children (and now adults) at 133 percent of FPL. Although the law allows for exemptions due to state budget deficits as of 2011, ACA nonetheless reaffirms the federal commitment to health coverage for low-income children. ACA also maintains the CHIP program until 2019, with funding ensured through federal fiscal year 2015.

Actions needed:

1. Advocacy. Child advocates need to work to maintain Congress and CMS's support of oral health within Medicaid and CHIP and support states to expand dental coverage to adults.
2. Medicaid. State policymakers should maintain or recognize the importance of dental coverage for pregnant women, adults and persons with disabilities within and newly eligible for Medicaid.

- **Dental Workforce and Training**

Providing dental care requires a sufficient number of dental personnel who are well trained and accessible, particularly to those who have had least access to dental care in the past. ACA's many dental provisions address workforce, training, and payment issues that advance the goal of access for all, including those children who will be newly insured.

ACA includes several provisions to improve the types, numbers, qualifications, and availability of the dental care workforce. These provisions

- ✓ Create a National Health Care Workforce Commission with attention to the capacity of the dental workforce. The Commission will study and make recommendations to Congress on assuring a qualified health care workforce with sufficient capacity to meet the needs of Americans, including the sufficiency of the dental workforce. This 15 member entity was formed in September 2010 to coordinate with federal agencies and advise Congress on meeting the demand for health care workers, identifying and correcting barriers to workforce sufficiency, and encouraging innovations to address population needs. The Commissioners (who are primarily not healthcare providers) will "communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce." The Commission will review current and future workforce supply and distribution

including educational infrastructure, the “Title VII” and graduate medical education training programs; needs of underserved and special populations; and loan and scholarship programs. Among listed “high priority” areas is “the education and training capacity, projected demands, and integration with the health care delivery system of oral health care workforce capacity at all levels” (Section 5101).

- ✓ Expand federal training support for primary care dentistry. Authorization for dental workforce training was increased to \$30M; expanded to include dental hygienists in addition to general, pediatric and public health dentists; and designated for a unique appropriations line item that separates Congressional primary care funding for dentistry from medicine. These grants target primary care dental training to the needs of underserved populations. Congress focuses dental training on preparing dentists and hygienists to care for underserved populations with the greatest disease experience through new pre-doctoral and continuing dental education programs. Monies may also be used to enhance dental education capacity through faculty development and loan repayment programs that encourage capacity development in the fields of public health, pediatric dentistry, general dentistry, and dental hygiene. Funding also supports students, dental/dental hygiene primary care practitioners, and faculty and for technical assistance to pediatric dentistry training programs. In response to ACA’s March 23, 2010 passage, HRSA’s Bureau of Health Professions which administers these grants retracted outstanding grant guidance and reissued the guidance to reflect all of these changes except the technical assistance provision (Section 5303).
- ✓ Institute a new alternative dental provider demonstration program. Congress authorized \$20M over five years for up to 15 states to demonstrate the development and employment of new dental providers to address needs of underserved populations and charged the Institute of Medicine with conducting an evaluation of these efforts. The law also requires that these demonstrations comport with state practice acts. Prior to obtaining grants for training of alternative providers who would provide intraoral services, states would need to have accommodating practice acts. (See above for alternative providers who would provide educational and case management services but not technical intraoral dental services.) Currently few states appear to meet this requirement. Currently only Minnesota sanctions dental therapists—non-dentists who deliver dental prevention, filling, and limited extraction services. California’s “Health Workforce Pilot Projects” program, described above, may serve as a model for states that do not wish to sanction new dental providers but do wish to experiment with such alternatives (Section 5304).
- ✓ Create a multidisciplinary predoctoral “Public Health Sciences Track” for healthcare providers including dentists. The Secretary of DHHS is authorized to designate and fund educational programs and students – including 100 dental students annually – to tailor studies to “team based services, public health, epidemiology, and emergency preparedness and response.” Graduates will be required by the Surgeon General to pursue residencies in applicable fields and to serve in the US Public Health Service two years for each year of federal tuition and stipend support up to 8 years. Faculty and program graduates may be appointed to a new “Elite Federal Disaster Team” managed by the Surgeon General to respond to emergencies including “public health emergencies, natural disasters, and bioterrorism events” (Section 5315).

- ✓ Increases post-doctoral dental training support. ACA increases funding for new and expanded primary care residency programs and increases Graduate Medical Education support for hospital-based programs, including post-doctoral dental programs (Section 5508).

Actions needed:

1. Fulfill Funding. Child advocates' and organized dentistry's appropriations request for FY2012 was \$30.0M.
2. Improve Educational Infrastructure. Dental Educators need to
 - work with their University Medical Centers to consider interest and capacity to become designated training sites for the Public Health Sciences Track
 - develop short and long-term plans to maximize the pre-doctoral, post-doctoral, and faculty support options made newly available
 - work with state legislators to prepare for education and training opportunities afforded by the alternative dental provider grant program
 - work with affiliated hospitals to avail themselves of expanded graduate medical education funding
3. State Legislation. State legislators need to consider dental practice act modifications, including the model California Health Workforce Pilot Projects, to prepare for their state's participation in the alternative dental provider grant program.
4. Advocacy. Child advocates and organized dentistry needs to encourage the Secretary to ensure that HRSA develops guidance and a grant competition for the new Title VII Health Professions Training technical assistance provision.
5. Prioritize Training. The current Institute of Medicine Committee on the Oral Health Initiative needs to develop specific recommendations to HRSA Bureau of Health Professions and other DHHS agencies to advance the intent of dental workforce provisions by prioritizing training in evidence-based disease management, medical-dental coordination and collaboration, and multidisciplinary and conjoint health professional education.

- ***Dental Safety Net***

ACA expands the capacity of two specific safety net approaches, both of which may include dental services. The dental safety net in the US is very small,²⁵ comprised of less than 5% of US dentists practicing in health centers, hospitals, dental schools, and public clinics. ACA's expansion of the safety net provides unique opportunities to expand the size and availability of the dental safety net for those who currently have limited access to private dental care.

The "Grants for the Establishment of School-Based Health Centers" (SBHCs) program establishes a \$50M fund for facilities, inclusive of acquisition and construction, and equipment purchase. Priority is given to sites that preferentially serve children in Medicaid and CHIP with comprehensive services.

Comprehensive services are defined as providing "health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services." This language fails to recognize that an increasing number of SBHCs provide dental services directly. Of the over 1,900 school-based health centers currently operating nationwide, the majority offer dental education; about one quarter provides dental examinations, sealants and screenings; and approximately one tenth provides reparative dental services to students.²⁶ Larger numbers of schools participate in school-based dental sealant programs (described above) which could

be expanded to provide more comprehensive services. The Institute of Medicine's study of adolescent health care²⁷ encourages additional development of SBHCs for adolescents as age-appropriate and readily accessible venues for comprehensive health care, including dental care. Much greater support is provided through an additional \$11B support over the period FY2011-2015 for expansion of community health centers. These expansions may support both intramural dental program expansions and extramural expansions by contracting with private dentists. FQHCs are the most substantial component of the dental safety net. They provide a range of medical services to 16 million people and offer preventive dental care in over 70% of sites.²⁸ In 2008, the 1080 FQHCs provided oral examinations and preventive services to 2.3 million people, dental reparative services to 1.2 million people, and emergency and oral surgical services to nearly 800,000 people.²⁹

Actions needed:

1. Advocacy. Child advocates and organized dentistry need to
 - develop an appropriations request for FY2012 that specifies fund allocation to dental infrastructure development in both SBHCs and FQHCs
 - encourage Congress to prioritize oral health in safety net settings
 - work with Congress and the National Assembly of School Based Health Centers (NASBHC) to expand the legislative definition of dental care beyond referral and monitoring to include direct services, coupled with school based sealant programs.
2. Improve Coordination of Care. The IOM's Committee on Access to Dental Care and Committee on the Oral Health Initiative need to recommend aggressive integration of oral health care within the SBHC and FQHC safety net.
3. Provide Adequate Training. Dental Educators need to explore pre- and post-doctoral training opportunities within SBHC and FQHCs.

- ***Provider Payment***

Dental professionals have long been concerned with payment rates in public insurance programs. While physicians' payments in Medicare have long been the purview of "MedPAC," the Medicare Payment and Access Commission, there has been no comparable Congressional Commission to address payment and access in Medicaid and CHIP. CHIPRA established the analogous "MACPAC," the Medicaid and CHIP Payment and Access Commission and ACA expanded MACPAC's responsibilities. The 17 member Commission, which must include a dentist, is charged with reviewing payment methodologies and how payment impacts access to care; developing an "early warning system to identify provider shortage areas or any other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries"; reviewing federal agency reports to Congress and regulations regarding Medicaid and CHIP; and advising Congress on how payment arrangements "enable beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations." Additional responsibilities include attention to eligibility, enrollment, benefits, and quality.

Actions Needed

1. Advocacy. Child advocates and organized dentistry need to
 - monitor MACPAC public meetings, encourage MACPAC’s Chairman and Executive Director to attend to dental care financing issues, and comment on MACPAC reports to Congress.
 - encourage Congress to charge MACPAC with conducting an analysis and making recommendations regarding the impact of provider payments in Medicaid and CHIP on provider participation and dental access/utilization.
2. Provide Data. Advocates and dental health services researchers need to provide data and study findings to MACPAC that support its mission and methodology.

- ***State oral health infrastructure***

For the Act’s many dental provisions to succeed in improving oral health and dental care, federal and state oral health programs must be better positioned to coordinate the variety of existing and new programs; assert meaningful leadership and provide substantive guidance; implement dental public health strategies; and thoughtfully assess programmatic impacts through surveillance. ACA attends to each of these needs.

ACA authorizes “such sums as necessary” for fiscal years 2010 through 2014 to expand the 19 state cooperative agreements between CDC and state oral health programs to all states, territories, and Indian groups. The purpose of these agreements is “to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.” As the 19-state program has yielded substantial impact, replication holds strong promise to meet the goal of improved oral health. Under the existing program, states have developed state-wide and local oral health collaboratives, partnered widely with philanthropic and health professional organizations, expanded community water fluoridation and sealants, developed state-level oral health action plans, improved surveillance, explored novel approaches to population-level care including systems dynamics modeling, and improved policy liaison between legislative and administrative branches.

Actions needed:

1. Fulfill Funding. Child advocates’ and organized dentistry’s appropriations request for FY2011 and FY2012 was \$25M.
2. Promote the Program. Child advocates and organized dentistry need to document the positive impact of the existing 16 state program on oral health, identify and disseminate best practices, and encourage states to adopt successful strategies.
3. Evaluate the Program. The Institute of Medicine’s two oral health committees need to report on the positive impact of the existing infrastructure programs and recommend their active implementation in all states, territories, and Indian organizations.

Moving the Agenda on Dental Care

By addressing both dental coverage and the determinants of dental access (workforce, safety net, payment, and infrastructure), ACA provides the most comprehensive approach to dental care in history. The many provisions described, if fully funded and implemented, hold strong promise to ensure access to dental care for all U.S. children. Evidence also suggests that by extending medical coverage to all adults, ACA may also increase use of dental services by adults, even those without dental coverage. Much work remains to be done, particularly in defining the dental benefit for children that will be offered through the state Exchanges in 2014. In the meantime, the law promotes immediate enhancements in dental training, expansions in the dental safety net, a mechanism to address providers' concerns about payment rates in public insurance programs, and improvements in state-level oral health infrastructure. Taken together, these comprehensive efforts will improve access to quality dental care while muting many of the disparities that now characterize use of dental services.

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¹ US Department of Health and Human Services, Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services, Epidemiology Analysis Program Office, The Community Guide Branch. "The Community Guide." <http://www.thecommunityguide.org/index.html>. Accessed 8-6-10

² American Academy of Pediatrics. "Bright Futures." <http://www.brightfutures.org/>. Accessed 8-6-10

³ Marcus M, Reifel NM, Nakazono TT. Clinical measures and treatment needs. *Adv Dent Res*. 1997 May;11(2):263-71.

⁴ National Institute for Dental and Craniofacial Research. Take your child to the dentist. Available at <http://www.nidcr.nih.gov/OralHealth/Topics/ToothDecay/AHealthyMouthforYourBaby.htm>. Accessed 7/27/10

⁵ National Institute for Dental and Craniofacial Research. Centers for Research to Reduce Disparities in Oral Health Program. Available at http://www.nidcr.nih.gov/GrantsAndFunding/NIDCR_Centers_and_Research_Networks/CentersforResearchtoReduceDisparities/. Accessed 7-7-0.

⁶ American Academy of Pediatric Dentistry Reference Manual. Definition of Dental Home. 2007 *Pediatr Dent* 29(7):10.

⁷ Edelstein BL. Environmental factors in implementing the dental home for all young children: Background paper for Maternal and Child Health Bureau dental home meeting 9/17/08. Children's Dental Health Project, Washington DC. 2009. Available at http://cdhp.org/resource/environmental_factors_implementing_dental_home_all_young_children_0. Accessed 8-6-10.

⁸ Palmer C. Congress funds Iowa dental home demonstration project. *ADA News* 6/17/10. American Dental Association, Chicago IL. Available at <http://www.ada.org/news/4297.aspx>. Accessed 8-9-10.

⁹ Newacheck op cit

¹⁰ Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine. *Defining Primary Care: Interim Report*. 1994. Washington, DC: Institute of Medicine, National Academy Press;1994.

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- ¹¹ USPSTF. Counseling for dental and periodontal disease at [www.ahrq.gov/clinic/uspstf/uspstf.htm](http://www.ahrq.gov/clinic/uspstf/uspstf/uspstf.htm) Accessed 7/28/10
- ¹² (USPSTF. Prevention of dental caries in preschool children. At [http://www.ahrq.gov/clinic/uspstf/uspstf.htm](http://www.ahrq.gov/clinic/uspstf/uspstf/uspstf.htm). Accessed 7/28/10.)
- ¹³ American Academy of Pediatrics. "Fluoride Information by State." Available at: <http://www.aap.org/oralhealth/fluoride.cfm>. Accessed 8-6-10.
- ¹⁴ Children's Dental Health Project. The interface between medicine and dentistry in meeting the oral health needs of young children. American Academy of Pediatric Dentistry, Chicago IL. Available at <http://cdhp.org/system/files/The%20Interface%20Between%20Medicine%20and%20Dentistry%20in%20Meeting%20the%20Oral%20Health%20Needs%20of%20Young%20Children.pdf>. Accessed 8-6-10.
- ¹⁵ American Academy of Pediatrics. Oral Health Initiative. Available at <http://www.aap.org/oralhealth/>. Accessed 8-6-10.
- ¹⁶ Douglass JM, Douglass AB, Silk HJ. A practical guide to infant oral health. Am Fam Physician 2004;70:2113-2120.
- ¹⁷ Oral Health Section, Division of Public Health, State of North Carolina. 2008-2009 Annual Report: North Carolina oral health section. State of North Carolina. Raleigh NC. Available at <http://www.communityhealth.dhhs.state.nc.us/dental/Staff%20Forms/08-09%20OHS%20Annual%20Report.pdf>. Accessed 8-6-10.
- ¹⁸ Manski, R. J. and Brown, E. Dental Use, Expenses, Private Dental Coverage, and Changes, 1996 and 2004. Rockville (MD): Agency for Healthcare Research and Quality; 2007. MEPS Chartbook No.17. Available at http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb17/cb17.pdf. Accessed 8-9-10.
- ¹⁹ Edelstein BL, Williams S. Analyses of the Commonwealth Fund 2001, 2003, and 2005 biennial health insurance surveys. 2010. Columbia University College of Dental Medicine Section of Social and Behavioral Sciences. New York, NY.
- ²⁰ Manski RJ, Brown E. Dental use, expenses, private dental coverage, and changes, 1996-2004. Rockville (MD): Agency for Healthcare Research and Quality;2007. MEPS Chartbook No.17. available at http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb17/cb17.pdf. Accessed 8-16-10.
- ²¹ *ibid*.
- ²² Macek MD, Manski RJ, Vargas CM, Moeller JF. Comparing oral health care utilization estimates in the United States across three nationally representative surveys. Health Serv Res. 2002;37:499-521
- ²³ Liu J, Probst JC, Martin AB, Wang J-Y, Salinas CF. Disparities in dental insurance coverage and dental care among US children: the National Survey of Children's Health. *Pediatr* 2007;119:S12-S21.
- ²⁴ *ibid*
- ²⁵ Edelstein, B. The dental safety net, its workforce, and policy recommendations for its enhancement. *J Pub Health Dentistry* 2010; 70:S32-39.
- ²⁶ Strozer J, Juszczak L, and Ammerman A. 2007-2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care. 2010.
- ²⁷ US National Academy of Sciences, Institutes of Medicine. Adolescent health services: Missing opportunities. Available at: <http://www.iom.edu/Reports/2008/Adolescent-Health-Services-Missing-Opportunities.aspx>. Accessed 8-6-10.
- ²⁸ Institute of Medicine. 2009. The U.S. oral health workforce in the coming decade: Workshop summary. Washington DC: The National Academies Press pages 44-45.
- ²⁹ US Department of Health and Human Services, Health Resources and Services Administration. Selected Diagnoses and Services Rendered, National Summary for 2008. Available at http://www.hrsa.gov/data-statistics/health-center-data/NationalData/2008/2008_national_diagnoseservices.html. Accessed 1/15/10.