Shaping Policies that Affect Community Health Centers and Their Communities

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Pew Center on the States

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www.pewcenteronthestates.org/dental
Agenda

- State and federal policies that affect
  - Community health centers
  - Their clients

- Overview of Pew Children’s Dental Campaign
  - Why?
  - What policies?

- Opportunities of ACA

- NNOHA initiative to develop capacity to change policy

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Policies that Impact Community Health Centers

- Grant ($) to CHC
- HRSA Regulations (Personnel, Services, Reporting, etc.)
- Scope of practice of dental team
- Medicaid coverage (adults?) and rates
- Others?
- Compounded sometimes by federal preemption of state law
Policies that Impact Clients of CHCs

- Justify a FQHC in their community
- Funding for a FQHC and its adequacy
- FQHC accountability
- CHC dental clinic efficiency
- Who is covered by Medicaid and CHIP
- Support for medical providers to address OH of toddlers
- Community water fluoridation
- OH components of WIC and Headstart
- School-based sealant programs
- Food stamps, tobacco control, transportation, others

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Shaping Policies that Impact CHCs and their Clients

- NACHC
- State and regional primary care associations
- National and state medical associations
- American Dental Associations
- State Dental Associations
- Social change advocacy groups
- NNOHA
Children’s Dental Campaign: Advancing Children’s Dental Health

Mission:
To promote policies that will help millions of children maintain healthy mouths, get the care they need and come to school ready to learn.
About The Pew Center on the States

The Pew Center on the States helps build high-performing states that:

1. Work efficiently and effectively to deliver better results.

2. Achieve long term fiscal health through budget discipline.

3. Make smart investments in programs that provide the strongest returns.
Three Policy Areas—Current Focus

Prevention
- Community water fluoridation—campaigns
- National messaging and strategy development

Funding for care
- Advocating for appropriations for oral health programs
- Medicaid reimbursement for fluoride varnish by MDs and RNs

Workforce
- Ensuring adequate workforce to care for children
- Research on economics of new models
• Supported by W.K.Kellogg Foundation and the DentaQuest Foundation
• 8 policy benchmarks
The Report

Graded 50 states and the District of Columbia on eight measures in these areas:

- **Cost-effective prevention** (school-based sealant programs and community water fluoridation)
- **Medicaid performance**—how states are doing in getting dentists to treat low-income children
- **New workforce models** that expand the number of providers to care for children
- **More and better information** gathering data to measure and improve performance
The 8 benchmarks:

- At least 75% of water supplies are fluoridated
- 25% of low income schools have a sealant program
- Dentists exam not required before hygienists apply sealants
- Medicaid rates for dentists are higher than cost of providing care
- 38% or more Medicaid children had a dental visit
- Medicaid reimburses physicians for fluoride varnish
- State licenses new primary care dental providers
- State submits children’s dental health data to NOHSS
Bad news/good news

Bad news:
• 17 million children—or one child in five—go without access to dental care
• Two thirds of the states are doing a poor job of enacting policies to ensure children’s dental health

Good news:
• This is fixable with a handful of effective policies
• A number of states are leading the way
Only Six States Earned an “A” by Meeting at Least 6 of the 8 Benchmarks

- Diverse in size and geography
- Addressing the issue using a wide range of tools
- Despite an “A” grade, there is much room for improvement
Nine States Met Only 1 or 2 Benchmarks

- Not taking advantage of low- and no-cost interventions
  - Hygienist regulation
  - Use of medical providers
- NJ – the lowest performer – meets only 1 benchmark
33 States and DC Received a C or Lower
Why did we do it?

- Report card format works to get media and policymakers’ attention
- Report tells a story—can attract people new to the issue
- Give advocates, foundations, associations, state officials a tool to use to push agenda
- Establish a starting point to track state progress
- Give states ideas for cost-effective solutions
Raising the Grade: 1. Cost-Effective Prevention

School-based sealant programs are a cost-effective preventive strategy. Sealants are protective coatings that cost one third what a filling costs, and prevent 60% of cavities.

Water fluoridation is one of ten great public health achievements of the 20th century (CDC). It saves up to $38 in treatment costs for every $1 invested. But 30% of Americans on community water systems don’t get fluoridated water. Texas has seen $24 per child in Medicaid savings from fluoridation.

<table>
<thead>
<tr>
<th>% of high-risk schools with sealant programs, 2009</th>
<th>Number of states</th>
</tr>
</thead>
<tbody>
<tr>
<td>75-100%</td>
<td>3</td>
</tr>
<tr>
<td>50-74%</td>
<td>7</td>
</tr>
<tr>
<td>25-49%</td>
<td>7</td>
</tr>
<tr>
<td>1-24%</td>
<td>23</td>
</tr>
<tr>
<td>None</td>
<td>11</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>% of population on community water supplies receiving optimally fluoridated water, 2006</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% or greater</td>
<td>26</td>
</tr>
<tr>
<td>50-74%</td>
<td>16</td>
</tr>
<tr>
<td>25-49%</td>
<td>7</td>
</tr>
<tr>
<td>Less than 25%</td>
<td>2</td>
</tr>
</tbody>
</table>
Raising the Grade:  
2. Strong State Oral Health Programs

• Every state needs strong oral health programs focused on prevention and reaching children at highest risk.

• And states need federal support for prevention. Only 19 states receive CDC funding for infrastructure and capacity to guide prevention strategies. We need it in every state.
Raising the Grade: 3. Improving State Medicaid Dental Programs

- All Medicaid-enrolled children are entitled to dental care. Only Alabama, Texas, and Vermont provide dental care to more than half of their enrollees under the age of 18.

- High-grade states have shown the way: program changes in Rhode Island saw dentists’ participation in Medicaid grow from 27 to 217 – nearly half of the state’s dentists.

<table>
<thead>
<tr>
<th>% of Medicaid children receiving any dental service, 2007</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>59% or greater</td>
<td>0</td>
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<tr>
<td>50-58%</td>
<td>3</td>
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<tr>
<td>38.1-49.9%</td>
<td>26</td>
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<tr>
<td>30-38%</td>
<td>13</td>
</tr>
<tr>
<td>Less than 30%</td>
<td>9</td>
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</table>
Raising the Grade:
4. Innovative Workforce Models To Expand Access

- *Physicians* can provide preventive dental care to young children. An evaluation in North Carolina is expected to show a 40% reduction in cavities among participants.

- *Dental therapists* have been used around the world for decades to expand access to basic dental care; in 2003, Alaska tribes began using “DHATs.” In 2009, Minnesota became the first state to authorize dental therapists.

- Health care reform legislation specifically authorizes demonstrations of new allied dental providers, and allows the expansion of DHATs in tribal lands (under state law).
Media Coverage

245 television and radio airings in 107 markets

- Articles in USA Today, The Columbus Dispatch, Hartford Courant, and The Tallahassee Democrat

Video footage ran 231 times on 135 television stations, and on over 400 radio stations, reaching millions

15 radio interviews, including statewide networks in North Carolina, Iowa, Pennsylvania, the Dakotas, and Texas

- Stories on NPR and CBS Radio

Interview requests still coming!

Quad City Times (IA), “Kids' dental care earns 'A,'” February 24, 2010


Hartford Courant (CT), Connecticut Improves Dental Care For Children, Pew Report Says,” February 24, 2010
Examples of Use by Advocates

- New York State Oral Health Coalition (NYSOHC) – sent out packet and outlined steps the state needs to take
- OHAC – action alert announcement by California coalition urging legislative action
- *Harold Net* – advocates in Washington State placed an op ed stating “early dental care for all is essential, medically and morally”
Lessons Learned

• Data and methodology have to be airtight
• Grading approach works to get media, policymaker attention, but has detractors
• Work closely with foundations, partners and potential critics to help them use it
• Do an evaluation (informal or formal) to plan next steps
Where is Pew working?

- **Fluoride Varnish**
- **Fluoridation**
- **Workforce**
Why Do We Need Change?

281 million

198 million have access

83 million lack access
The Financial Costs

Medicaid spends between $100 million and $400 million each year on children who end up in the operating room with advanced disease. These costs are avoidable.

— data from Burton L. Edelstein, DDS, MPH

*The Cost of Caring: Emergency Oral Health Services*

The Human Costs: The Driver Story

“It took the combined efforts of one mother, one lawyer, one helpline supervisor, and three health care case management professionals to make a dental appointment for a single Medicaid-insured child!”

— Laurie Norris, JD; Congressional Testimony
More Kids, Same Old System

• Financing for dental care likely to grow, will spur demand
  – An estimated **5.3 million** more children will have dental insurance by 2014

• Few private practice dentists participate in Medicaid and CHIP
  – Medicaid rate increases don’t solve problem

• Shortage and maldistribution of dentists
  – Too few care for low income, rural patients
  – Dental safety net only reaches 10% of 83 million lacking access
  – New providers can deliver high-quality care
Barriers to Care for the Underserved

- Low health literacy and expectations
- Medicaid and CHIP eligibility paperwork
- Lack of access to transportation, paid personal/sick days, and childcare
Health Professional Shortage Areas (HPSA) - Dental Health
HPSA Clinician Priority Scores

Source: Health Resources and Services Administration - HRSA, Bureau of Health Professionals; July 6, 2010.

Note: Alaska and Hawaii not shown to scale
6,620 Practitioners Needed to Remove Designation of Health Professional Shortage Area

Numbers = Practitioners Needed to Remove Designation
## ESTIMATED NUMBERS OF RETIRING DENTISTS AND DENTAL GRADUATES, 2001-2020.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DENTISTS RETIRING*</th>
<th>DENTISTS GRADUATING†</th>
<th>RATIO</th>
<th>DIFFERENCE</th>
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<tr>
<td>2001</td>
<td>3,546</td>
<td>4,090</td>
<td>.867</td>
<td>-544</td>
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<td>3,631</td>
<td>4,130</td>
<td>.879</td>
<td>-499</td>
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<td>2003</td>
<td>3,754</td>
<td>4,172</td>
<td>.900</td>
<td>-419</td>
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<tr>
<td>2004</td>
<td>3,805</td>
<td>4,213</td>
<td>.903</td>
<td>-409</td>
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<td>2005</td>
<td>4,028</td>
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<td>2006</td>
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<td>4,298</td>
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<tr>
<td>2007</td>
<td>4,226</td>
<td>4,341</td>
<td>.974</td>
<td>-115</td>
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<td>2008</td>
<td>4,447</td>
<td>4,385</td>
<td>1.014</td>
<td>62</td>
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<tr>
<td>2009</td>
<td>4,563</td>
<td>4,428</td>
<td>1.030</td>
<td>135</td>
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<tr>
<td>2010</td>
<td>4,816</td>
<td>4,472</td>
<td>1.077</td>
<td>344</td>
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<td>2011</td>
<td>5,029</td>
<td>4,517</td>
<td>1.113</td>
<td>512</td>
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<td>2012</td>
<td>4,928</td>
<td>4,563</td>
<td>1.080</td>
<td>365</td>
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<tr>
<td>2013</td>
<td>5,117</td>
<td>4,608</td>
<td>1.110</td>
<td>509</td>
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<tr>
<td>2014</td>
<td>5,114</td>
<td>4,654</td>
<td>1.099</td>
<td>460</td>
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<tr>
<td>2015</td>
<td>5,114</td>
<td>4,701</td>
<td>1.088</td>
<td>413</td>
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<td>2016</td>
<td>5,233</td>
<td>4,748</td>
<td>1.102</td>
<td>485</td>
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<td>5,060</td>
<td>4,795</td>
<td>1.055</td>
<td>265</td>
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<td>2018</td>
<td>5,237</td>
<td>4,843</td>
<td>1.081</td>
<td>394</td>
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<td>2019</td>
<td>5,003</td>
<td>4,892</td>
<td>1.023</td>
<td>111</td>
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<tr>
<td>2020</td>
<td>4,965</td>
<td>4,941</td>
<td>1.005</td>
<td>24</td>
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* Assumes that 20, 50, 20 and 10 percent of dentists retire after 40, 35, 30 and 25 years in practice, respectively, and that the average age of retirement is 62 years.

† Based on the average annual rate of growth (1.0 percent) of first-year enrollments from the 1989 to 1990 school year to the 1998 to 1999 school year.

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The Opportunity:
ACA Workforce Provisions
ACA Support of Dental Workforce Expansion

- Most of the new dental provisions in ACA are authorized but not appropriated.
- Money appropriated in ACA is not specifically targeted to dental access issues:
  - Community health center funding
  - Prevention and Public Health Trust Fund
- Work still remains to be done to adequately fund these provisions (appropriation and allocation).
ACA Support of Dental Workforce Expansion

Demonstrations and evaluation of alternative dental health care providers (Title V, Sec. 5304)

Expanded dental training programs (Title V, Sec. 5303)

New or expanded primary care residency programs, including dental programs (Title V, Sec. 5508)

Funds for Community Health Centers (Title X, Section 10503)
Pew’s Workforce Portfolio
Pew’s Workforce Initiatives

State Level:
- Current: MN, CA, ME
- Upcoming: NH, CT

Federal Level:
- Secured provisions on DHAT in HCR
- Advocating for appropriations that support workforce

Research
- Publication: “Help Wanted” – decision framework for states
- Several projects underway
University of California, San Francisco Center for the Health Professions

Lead investigators
Elizabeth Mertz, PhD, MA, and Catherine Dower, JD

Question
How can medical collaborative practice models be applied to and affect the dental care delivery system?

Release Date
December 2010
UCSF Study will

Explore what states could mean by ‘collaborative practice’:

1. Collaboration between Operationally and Legally Independent Providers
2. Collaboration between Operationally Independent Providers
3. A Single Health Care Organization
4. A Public Health Entity
5. Ancillary Settings
University of Connecticut Health Center (UCHC)

Lead investigators
Howard Bailit, D.M.D., Ph.D. and Tryfon Beazoglou, Ph.D.

Question
What are the likely effects of new dental care providers on FQHCs, and what is the most effective way to utilize those providers to increase access to care?

Release Date
Spring 2011
UCHC Study will:

- Evaluate data from FQHCs in CA, ME, WI, CT
- Provide economic model to estimate impact of new providers on FQHC dental clinic productivity and finances under two conditions:
  (a) new provider training and delivery system organizations
  (b) Medicaid program design and FQHC payment methods and reimbursement rates.
- Test economic model on selected FQHC dental programs
Scott & Company

Lead investigator
Mary Kate Scott

Question
What are the potential economic impacts of hiring new allied dental care providers to a dentist practice?

3 scenarios: solo general practice; pediatric practice; small group practice. Excel “calculator” will be available for download by any user.

Release Date
Soon

Pewcenteronthestates.org/dental
NNOHA Advocacy and Strategic Partnerships

Why is now the time?
New opportunities in the Affordable Care Act

Rebecca Alderfer
Senior Associate, Government Relations
Pew Children’s Dental Campaign

June 20, 2010
Pew Campaign Federal Agenda: Supporting State Policy

- Increasing federal financial investments in oral health prevention and care; including workforce
- Improving federal Medicaid, CHCs, and grant program policies and criteria to ease barriers to care
- Showcasing state models for pragmatic, cost-effective reform and recruit national champions
- Serving as a resource and liaison to federal policymakers and state campaign advocates
Dental Coverage in the Affordable Care Act

Essential Health Benefits Requirements
A pediatric dental benefit is required in the essential benefits package of the new State exchanges.

Medicaid Expansion for the Lowest Income Populations
Mandates that states set their Medicaid income eligibility cap no lower than 133% of FPL. Coverage extended to all citizens meeting the income eligibility standard (childless adults).

Extends CHIP through FY 2015
Programs with Direct Funding in ACA

Community Health Centers Fund
Appropriated $11 billion to the CHC program
• $9.5 billion to expand operational capacity and enhance health services, including oral health services
• $1.5 billion for construction and renovation of community health centers

National Health Service Corps Fund
Appropriated $1.5 billion to the National Health Service Corps
• Placement of estimated 15,000 primary care providers in shortage areas

Grants for the Establishment of School-Based Health Centers
Restricted to $ for facilities; cannot be used for operations
Authorized Discretionary Oral Health Programs in ACA

- 5-year national, public education campaign focused on oral healthcare prevention and education
- Demonstration grants to show the effectiveness of research-based dental caries disease management activities
- Expanded oral health surveillance; national and state specific
- Expanded cooperative agreements to improve oral health infrastructure of state OH programs
Authorized Discretionary Oral Health Programs in ACA

• Requirement that all states/territories/tribes receive grants for school-based dental sealant programs

• Demonstrations and evaluation of alternative dental health care providers
  To train/employ new types of dental providers to increase access to dental care in rural and other underserved communities.

• Expanded dental training programs
  Grants to establish and improve training programs, provide student financial assistance, and faculty loan repayment.

• School-Based Health Center Grants
  Required basic services include “referrals to, and follow-up for, specialty care and oral health services”
Discretionary (Annual) Appropriations for OH Programs

- Annual appropriations bill funding the Department of Health and Human Services
- Funding from the Prevention and Public Health Fund
  - New Fund via ACA provides for a sustained national investment in prevention and public health programs (over the FY 2008 level) growing annually to $2 billion in FY 2015 and thereafter.
  - Will support programs authorized by the Public Health Service Act, including prevention research, health screenings and initiatives
- How much of $500 million in FY 2010 went to OH?
- How much of $750 million in FY 2011 will go to OH?
- Thereafter?
We have our work cut out for us!

1.) There is no requirement that an authorized discretionary program receives an appropriation. P.L. 111-148 serves as an authorization bill for the oral health programs.

2.) The President has requested a 3-year freeze in discretionary spending along with a deficit commission to realign federal spending.

3.) The Senate Budget Resolution, passed by Committee, proposes less funding in FY 2011 and FY 2012 for the Function 550 Health programs than found in the FY 2010 budget resolution.

4.) The House recently passed a one-year budget enforcement bill that is both lower than the President’s budget and the Senate budget resolution.
What can NNOHA do?  Speak up!

Congressional Appropriators need to hear from constituents and interest groups that providing funding for the authorized oral health prevention and workforce programs is expected.

Action Needed:
NNOHA can prepare members to write and call their Representative and Senators
• Speak directly to the Health Legislative Assistants (L.A.s) in Congressional offices
• Strategically speak on behalf of entire NNOHA
• Develop partnerships to broaden advocacy
Talking Points for Calls & Letters

• Who YOU are may be the most important point to make to a policymaker or staff since “all politics is local.”

  – Explain the local need:

  (1) Explain state needs for funding and improved funding for oral public health, the dental safety net, and workforce
    • Example: Dental professional shortage areas, Waiting lists

  (2) Explain how these programs support the dental safety net

  (3) Clearly explain why your state needs to access these newly authorized resources
    • Example: Recent state budget cuts to dental insurance, public health programs, etc. – if any. Use the context of the recession.
Talking Points -- Continued

• Mirror back to Congress why they enacted Health Care Reform: “The Patient Protection and Affordable Care Act, is based on the belief that comprehensive insurance coverage and sound prevention will reduce the burden of disease and the costs of preventable illness.”

• How to make that real: States can help eliminate the pain, missed school hours and long-term health and economic consequences of untreated dental disease — if they have the option of using new federal funds for targeted investments in effective policy approaches.

• The consequences of poor dental health are far worse — and longer lasting — than many policy makers and the public realize; including impacts on early childhood development, school readiness and performance, overall health, and economic opportunity.
Talking Points -- Continued

• The law authorizes funding for new and expanded programs to prevent dental disease and augment the dental workforce so that those most in need of care receive it.

• FY 2011 appropriations, including an allocation from the Prevention and Public Health Fund, are necessary to fund the oral health programs contained in the law.
Summary

• New insurance coverage and new resources
  – Estimate 5.3 million children could gain dental coverage
  – Expansion of FQHC operational and facilities grants
  – Authorized programs supporting prevention and workforce

• **Action still needed**: To secure federal investment in authorized dental programs
  – Advocating for appropriations in FY 2011
  – FY 2011 allocation from Prevention and Public Health Fund
  – Advocating each year thereafter
The takeaway:

We have tremendous challenges, and new opportunities. What we’ve been doing hasn’t worked for 1/3 of the population. The ACA, expansion of the role of CHC dental programs in the community, and new workforce models have potential to increase access for children who need it most.
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