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Oral Health: State Policy Options

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Access to oral health services remains a major public health issue in the United States, with only 61 percent of adults 18 years and older visiting a dentist's office in 2013, according to the Centers for Disease Control and Prevention (CDC).[1] Nearly one-third of adults have untreated tooth decay.[2] Emergency room visits for preventable dental conditions cost $1.6 billion in 2012.[3] The "triple aim" addresses these issues by setting goals for health care, including oral health care, to improve the patient care experience, improve the health of the population and lower costs.

States have a variety of leverage points to improve adult oral health. This report outlines state policy options to improve access to oral health care, reduce oral health disparities, address oral health workforce issues, integrate oral health and primary care, and use public health models and data to achieve better oral health outcomes.

IMPROVE ACCESS TO ORAL HEALTH CARE FOR ADULTS

Poor access to dental services has economic consequences for states. In 2012, visits to the emergency room for dental reasons cost $1.6 billion and rarely addressed the underlying condition. Estimates show that 79 percent of these patients should have been treated in a community setting.[4] Medicaid is a major payer of these costs; a study of Maryland's Medicaid costs showed a potential savings of $4 million if dental visits to the emergency room were diverted to a more appropriate setting.[5] In addition, poor adult oral health is costly to both working people and employers. Employed adults lose more than 164 million work hours annually because of oral health problems or dental visits, according to the CDC.[6]

The vast majority of adults who gained or will gain some dental coverage through the Affordable Care Act (ACA)—about 17.7 million—will do so via state Medicaid programs.[7] Only an estimated 800,000 will gain coverage through the state or federal health insurance exchanges.

Medicaid dental benefits for adults are optional under federal regulations, and the benefits offered vary widely from state to state. Most states offer at least emergency services to adults when pain, infection or traumatic injury make dental services a medical priority. Fifteen states offer extensive benefits to adults, which include a mix of preventive and restorative services. In many cases, states struggle to find an adequate number of Medicaid oral health providers.[8] Dentists often decline to participate in Medicaid because of lower reimbursement rates than in the commercial market. According to the American Dental Association, 35 percent of dentists accept Medicaid patients. For adult services in states with at least limited benefits, the reimbursement rates averaged 40.7 percent of commercial reimbursement in 2014. Alaska, Arkansas and North Dakota had the highest reimbursement rates, at around 60 percent of the commercial rate.[9]

About 4.5 million of the adults that gained dental coverage with the passage of the ACA receive comprehensive benefits, which cover diagnostic, preventive, and minor and major restorative procedures.[10] The vast majority of these adults live in the 11 states that, as of 2015, already offer extensive dental benefits and are offering the same benefit package to their expansion population.[11] The majority of Medicaid expansion states offer the expansion population the same dental benefits the base population receives. Fourteen states provide coverage for emergency dental services for adults with Medicaid, such as coverage for uncontrolled bleeding or trauma.[12] The ACA's policies will decrease the number of adults without dental coverage by about 5 percent from pre-2010 levels.

State Policy Options to Improve Access to Oral Health Care

- Understand your state's Medicaid program coverage for adult dental benefits.
- Consider policies that ensure consumers can access dental insurance information on your state's health insurance marketplace, and that help adults understand their coverage.
- Learn about health insurance exchange procedures that ensure policyholders who purchase stand-alone dental plans are not paying more than the allowable maximum out-of-pocket costs.
- Some consumer protection laws that are mandated for health insurance plans do not extend to dental plans. Consider consumer protection laws similar to those required for physical health plans, such as implementing medical loss ratios.
- Encourage private insurance companies to structure plans that meet the needs of specific patient populations (e.g., covering additional hygiene visits for the elderly at risk for periodontal disease).
- Review Medicaid reimbursement rates and see how your state compares to others.
- Ease administrative burdens for dentists who want to be Medicaid providers. Consider ways to streamline the process, from applying for a Medicaid provider number to submitting claims.

REDUCE ORAL HEALTH DISPARITIES FOR ADULTS

According to the American Dental Association's Health Policy Institute, 35.4 percent of working-age adults visited a dentist in 2012. The CDC estimates that nearly one-third of U.S. adults have untreated tooth decay. A closer look at the statistics reveals disparities in oral health along socioeconomic, racial and ethnic, age and geographic lines. For instance, minorities die of oral cancers at almost twice the rate of whites, and rural residents are twice as likely as urban residents to lose their teeth.[13]

In addition, nearly 70 percent of Americans over age 65 do not have dental insurance.[14] Medicare does not cover dental benefits, and very few retiree health insurance programs include dental benefits. Medicaid coverage for adults varies by state. As baby boomers age, this issue will grow—72 million U.S. residents will be seniors by 2030.[15] Dental insurance can make a difference for aging adults; regular dental visits are 2.5 times more likely to occur for an older adult who has insurance than one who does not.[16]

Community health centers are often key providers of health services to those who otherwise would not receive care. According to the Health Resources and Services Administration, 75 percent of Federally Qualified Health Centers provide on-site dental services.[17] The centers that do not provide dental services often contract with private dental practices to serve their communities.

In an effort to help reduce disparities, states also use alternative means to reach patients who cannot access traditional care for various reasons. In addition to health centers, some states

also allow dental teams to practice in other community-based settings, such as assisted living facilities, preschools and health departments. These settings can help alleviate barriers to care for patients and save on patient costs such as transportation. It also can relieve some of the anxiety patients feel in a traditional dental office, including those with Alzheimer's, who often are more compliant if treated in a familiar setting. In addition, a 2010 California demonstration project called Virtual Dental Home showed that telehealth-enabled dental teams could provide comprehensive care for people who were inadequately served in a traditional dental setting.[18] The project's success led to a 2014 law that includes teledentistry as a specialty for Medicaid reimbursement. Florida is the only other state that covers some forms of teledentistry.

State Policy Options to Reduce Oral Health Disparities

- Consider whether available services respond to the needs of underserved individuals and review any community health assessments performed in your district. What are the barriers to good oral health?
- Consider incentives for dental students to practice in underserved areas.
- Work with your state's primary care association and state oral health program to encourage teaching rotations in community-based settings that specialize in underserved populations, such as Federally Qualified Health Centers. Consider special emphasis on clinics that integrate dental and medical care.
- Learn about the existing telehealth policies in your state. What barriers exist? Are your state policies conducive to telehealth innovation and teledentistry?
- Explore options for covering underserved adults. These policies could include one-time capital investments in safety net dental clinics; expanding the dental services offered to Medicaid beneficiaries; increasing Medicaid provider reimbursement rates; and funding health centers to provide dental services.

ASSESS ORAL HEALTH WORKFORCE NEEDS AND OPPORTUNITIES

Even with new professionals entering the field and the number of dentists slightly increasing each year since 2001, there are approximately 49 million Americans living in a designated dentist shortage area.[19] The Health Resources and Services Administration estimates that the country needs 7,300 new dentists to fill the

gaps. State legislatures have explored creative ways to ensure access to oral health care by addressing the workforce.

Around the country, there are 65 private and public dental schools. Some states have more than one dental school, but 14 states completely lack a dental education program, limiting their ability to grow their own dentists. It is common for these states to partner with neighboring state universities to reserve a number of seats for their students. To address workforce shortages in rural areas of the state, the North Carolina legislature committed more than $90 million between 2005 and 2009 to help create a new dental school at East Carolina University. Fourth-year students rotate through community service learning centers—dental clinics—in underserved areas. Thus far, all the graduates are North Carolina residents, and policymakers hope they will stay and practice in the Tar Heel State.

Diversity in the dental workforce, following similar trends across the nation, has come under increasing scrutiny in recent years. In 2008-2009, 59.9 percent of dental students, 78.6 percent of dental hygiene students and 60.2 percent of dental assisting students were white.[20] According to American Community Survey data from 2010 to 2012, only 9 percent of practicing dentists were black or Hispanic. Women also are underrepresented, making up 19 percent of all dentists. That number is expected to increase, however, since 44 percent of current dental students are female. These trends are important because research shows that professional diversity leads to better cultural competency and patient outcomes.

In recent years, states have designed education programs that seek to attract minority students earlier and put them on a medical track. In New Mexico, for example, the Semillas de Salud program is run through El Centro, a network of 16 Federally Qualified Health Centers that include three dental clinics serving rural northern New Mexico. The program recruits science-interested students as early as middle school and sees them through the entire educational process. The professionals, some of whom were born in the area, share the racial and ethnic heritage of the communities they serve.

To expand the reach of the oral health workforce, some states also are considering other alternatives. Although it is mentioned as an option to reduce disparities, teledentistry also can leverage and expand the reach of the existing workforce.

In addition, states are considering other provider policies. Many states expanded dental hygienists' licenses to allow greater scope of practice and/or practice in community-based settings. In 2014, 37 states allowed dental hygienists to provide certain preventive services to patients, often without direct supervision by a dentist, and 16 states allowed direct Medicaid reimbursement to hygienists, according to the American Dental Hygienists' Association.

States such as Alaska, Maine and Minnesota have created new provider types, such as dental therapists and community dental providers. As of July 2015, six states were considering legislation permitting licensure for dental therapists, who typically have training to perform basic restorative services, such as fillings and root canals on baby teeth, and non-surgical extractions. Data show the addition of a mid-level provider allows participating clinics to see more patients and adds revenue, in part by allowing the dentist to work at the top of his or her license.[21]

Eight states—Arizona, California, Montana, Minnesota, Oklahoma, Pennsylvania, Texas and Wisconsin[22]—are piloting another new type of provider, Community Dental Health Coordinators (CDHC), who are trained by the American Dental Association. In addition, in 2011, New Mexico enacted legislation creating CDHCs as a new provider type.[23] CDHCs usually are recruited from the same communities they serve. In addition to some basic, preventive services, they also may provide health education, connect patients with dental treatment, and arrange additional services such as transportation and child care.

State Policy Options to Strengthen the Oral Health Workforce

- Tie funding to train dental health professionals to the priority issues facing the state.

- Encourage health professional schools and safety net clinics to participate in professional education or pipeline programs and replicate them in other underserved areas.
- Facilitate or encourage partnerships with schools in other states to reserve seats for your dental students. Some may consider tying scholarships or other student support to agreements to return to the home state to practice.
- Talk with your state dental board and other stakeholders to understand the barriers and current policies related to developing a teledentistry program.
- Identify university partners and health foundations that might be willing to partner to train allied professionals, collect data and study the effectiveness of innovative practice models.
- If allowing mid-level dental professionals to practice is appropriate for your state, work with your state dental board and dental associations to ascertain what revisions are necessary to your state's dental practice act. Talk to colleagues in other states, such as New Mexico, who have passed similar legislation.

INTEGRATE ORAL HEALTH AND PRIMARY CARE

Efforts to improve oral health are increasingly examining the potential of integrating oral health and primary care. The connection between oral and physical health is well documented. For example, studies show significant annual cost savings for the medical treatment of diabetic patients when they receive regular periodontal care.[24] On the medical side, most state Medicaid programs reimburse pediatric primary care doctors and nurses for providing oral exams, screenings and preventive services, such as fluoride treatments and parent education.

Interprofessional education—where students learn about two or more professions to enable better cooperation—has become increasingly popular. The Smiles For Life program teaches health care professionals, from family practice physicians to geriatric specialists, to recognize signs and symptoms of problems, and to counsel patients about proper oral health care. Since 2010, more than 87,000 people have completed the free, online course for continuing education credit. In addition, the Department of Health and Human Services and the Health Resources and Services Administration developed the Integration of Oral Health and Primary Care Practice (IOHPCP) initiative, which encourages primary care safety net providers to apply oral health core clinical competencies in their practice.

Dentists also can help screen and identify people with other health issues. This type of chronic disease screening has the potential to improve care, reduce hospitalizations and save money. Every year, nearly 20 million Americans visit a dentist but not their doctor, according to a 2014 study in the American Journal of Public Health. If dentists screened for chronic diseases, the U.S. health system could save up to an estimated $102.6 million annually, or $32.72 per patient screened.[25] To address this, dental schools in Iowa, Maryland and New York are training students to screen for chronic conditions such as high blood pressure and diabetes. Several states also reimburse dentists for counseling Medicaid patients to quit smoking.

Managed care organizations (MCOs) and accountable care organizations (ACOs) offer additional opportunities for dental care. If properly structured, these organizations can improve the results, data collection and efficiency of dental health provision, as they have for regular health.[26] In Oregon, about 90 percent of the state's Medicaid beneficiaries are included in one of 16 local coordinated care organizations (CCOs). Oregon also moved its state employee health plan participants into CCOs. CCOs operate like accountable care organizations, in which providers are offered incentives to work together to improve patient health. Oregon requires CCOs to include dental care in their coordination and as part of the benefit package.

State Policy Options to Integrate Oral Health and Primary Care

- Consider financial incentives for dentists who screen for chronic diseases in their offices. Promote effective coordination between

dentists and physicians or community-based disease management programs to ensure continuity of care.

- Ensure that screening for oral health concerns and referrals for care are part of the patient-centered medical home model. Promote oral health as part of comprehensive primary care for patients with chronic conditions.
- Consider allowing Medicaid to pay for periodontal services and encourage patients with diabetes to take advantage of them. Educate chronic disease case managers about the role dental health plays in disease management.
- Look for ways to require or promote shared data systems across providers, so patient information is accessible to both physicians and dentists.
- Consider requiring MCOs or your Medicaid program to collect data that allow your state to study the interaction between medical and dental care.
- Explore incorporating dental services into your state's activity around accountable care organizations or innovative payment systems. Consider offering incentives for the outcomes you wish to improve by including dental-related quality measures or metrics providers must achieve.

EMPLOY ORAL PUBLIC HEALTH APPROACHES

A public health approach to oral health emphasizes prevention, evidence-based intervention and data collection. Although most adults say they do not access dental care because they can't afford it, 32.7 percent of adults surveyed by the American Dental Association in 2014 said they will not visit a dentist in the next 12 months because they don't think it's needed.[27] Young adults ages 18 to 34 were more likely than older adults to think they did not need preventive dental care.[28] Daily habits also can affect oral health, such as teeth brushing, diet choices and smok-

ing. For example, smokers are twice as likely to lose their teeth and need root canal treatment as non-smokers. Smokeless tobacco users are 50 times more likely to develop cancers of the cheeks, gums and lips than are non-users.[29] In addition, a 2011 study showed that 60 percent of people with substance dependence problems—especially those using opioids—rated their own oral health as "fair" or "poor."[30]

Community water fluoridation has proven to be a cost-effective public health measure to prevent tooth decay. For 70 years, adjusting the level of this naturally occurring mineral in public water supplies has helped prevent tooth decay for residents of all ages, especially for children whose adult teeth still are forming. The CDC estimates that every $1 invested in water fluoridation saves $38 in dental treatment.[31]

The decision to fluoridate the water supply typically is made at the local level and has met with resistance in some communities. Twelve states mandate fluoridation or regulate how the system functions. Twenty-six states and the District of Columbia meet or exceed the average national percentage (74.6 percent) of citizens who obtain their drinking water from a fluoridated system.[32] These rates vary, and in 13 states at least 60 percent of the adult population does not

have access to fluoridated water systems.[33]

States' oral health offices or divisions—usually an arm of the state public health agency—are dedicated to dental public health. All but four states have a full-time dental director, although the majority—34 directors—had been in their roles less than four years as of 2013.[34] Among other functions, these programs conduct surveillance to ensure that state and federal investments in prevention programs are working. They help local communities monitor and enforce laws to provide dental public health interventions, such as community water fluoridation and dental exams required for students to attend school. In addition, they provide scientific expertise for the public, practitioners, educators and legislators.

Thirty-nine states also have an oral health coalition that advocates for and advances oral health. Many of the coalitions germinated under the state offices of oral health, but in recent years were moved out to have a more independent voice in the policymaking process. Inherent in the mission of most such organizations is to build partnerships and collaborate statewide by engaging a variety of stakeholders; these coalitions also can share expertise with policymakers.

State Policy Options to Improve Oral Public Health

- Ensure public awareness campaigns are adequately funded and reach broader audiences through partnerships with employers, transit authorities or faith leaders.
- Consider approaches that promote healthy habits. Review your state's policies related to nutritional standards for foods and beverages served in public schools.
- Consider making oral cancer screenings widely available to populations with high tobacco use rates, and consider supporting or expanding tobacco cessation treatment and education programs.
- Educate yourself about community water fluoridation and determine its use in your district. Consider accessing information about fluoridation from organizations such as the CDC, the American Academy of Pediatrics and the American Dental Association.
- Familiarize yourself with your state oral health office's leadership, data and the essential public health functions they serve. Reach out to your state's oral health coalition to learn about their advocacy priorities and collaborative projects.

CONCLUSION

Although a single solution is not available, legislators have adopted a wide range of strategies to improve the oral health of adults in the United States. Regardless of the policy, common strategies to improve oral health care include the following options.

- Assess the magnitude of the problem. Gathering data about unmet oral health care needs and oral health workforce challenges can help legislators understand the most pressing problems in their state.
- Engage oral health stakeholders, including consumers, to review policies, identify challenges and opportunities, and develop effective programs.
- Align policies and investments to support evidence-based programs. Legislators play an important role by ensuring that programs and state funds support approaches that have proven results.
- Look at oral health workforce shortages from a different angle. States and localities are demonstrating that considering innovations in technology (e.g., teledentistry), redefining roles for dental hygienists and other care extenders, and integrating primary and oral health care can expand the reach of the current oral health workforce and improve access to care.
- Consider the return on investment of prevention. State and local public health departments are implementing and evaluating programs that aim to improve the population's oral health.

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