



**Identifying Policy Options to Improve Children's Oral Health:
A Report to the Florida Public Health Institute**

2010

FINAL REPORT

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Section I: Short-List of Opportunities for Change

Introduction:

Despite many challenges for oral health stakeholders in Florida, the “case for change” has never been more evident. Florida’s low level of dental services to low-income populations, including those in Palm Beach County, is reflected in the grade of “F” which was assigned to the state by the Pew Foundation’s recent state report card. Activists and their supporters in Florida are increasingly highlighting options and opportunities to improve oral health for Floridians.

Essential to improving oral health care in Florida is maximizing available payment streams. The Florida Public Health Institute (FPHI), in collaboration with the Children’s Dental Health Project (CHDP), seeks to advance opportunities to improve Medicaid and CHIP payment programs. This draft report details a list of such opportunities, many of which emanate from passage in 2009 of the Child Health Insurance Program Reauthorization Act. The report first highlights those opportunities that may be most immediately implemented even in Florida’s current fiscal and political climate, recognizing reports of an estimated \$1 billion Medicaid budget shortfall for 2010-2011.

The prioritized opportunities focus on the highest risk children and the earliest opportunities for intervention. They call for wide engagement of all who come in contact with families of low-income young children. They reflect five core approaches to improving oral health and dental care: prevention and disease management; strengthening the dental safety net; ensuring adequate workforce; providing sufficient financing; and conducting oversight, evaluation and surveillance.

Based on these principles, the following specific interventions are prioritized:

1. Prevention

Theme: Prioritizing the oral health needs of young children holds greatest promise for best health outcomes at lowest costs.

a) Develop and implement a model new parent education program in Palm Beach County that meets the new CHIP requirement to provide oral health education to parents of newborns.

b) Specifically develop and disseminate results of PBC pilot project on fluoride varnish application in pediatrician’s offices, along with updated information on Medicaid payment, either as part of the forthcoming business model or separately. (On February 12, 2010 ACHA clarified the policy which allows both Medicaid fee-for-service and health maintenance organizations to cover “application of fluoride varnish” and that ACHA will “reach out to the Medicaid HMO’s to ensure they are following this policy”).

c) Strategize on activities to collaborate (or further collaborate) with other early preventive programs such as the WIC Fluoride Varnish Program, in areas such as cross-training, outreach, and parent education.

2. Safety Net:

Theme: Maximize federal incentives to improve the dental safety net in PBC and statewide.

a) Actively promote public-private contracting between private practice dentists and FQHCs by engaging the local dental society and the local FQHCs in discussions around implementation. This approach was sanctioned by CHIPRA and can be implemented using a manual and model contract available from CDHP.

b) Maximize use of support services (translation, transportation, appointment making assistance) that qualify for 75% federal share in Medicaid.

c) Maximize use of ARRA (“stimulus funds”) available for funding expansions of community health centers (\$1.5B) and for health information technology.

3. Workforce:

Theme: Replicate workforce solutions that have been proven successful in other states.

a) Support policy change to permit dental hygienists to place sealants without a dentist’s prior examination in school-based sealant programs. A vehicle for this may be upcoming legislative initiatives that would allow delegation of specified dental hygiene services in a “health access setting” under “public health supervision.”

b) Facilitate development of off-site Pediatric Dentistry Residency Programs and Advanced Education in General Dentistry Residency Programs through Nova Southeastern and the University of Florida dental schools (with potential start-up support from HRSA).

c) Work with Florida’s dental schools on expanding off-site training, curricula around care of underserved populations, and extramural health promotion experiences.

4. Financing

a) Provide analytic information to oppose any expansion of the Miami-Dade capitation demonstration.

b) Actively promote raising Medicaid reimbursement to reflect market levels and correct Florida’s extremely low rate of reimbursement to dentists and administrative simplification

that models successes in other states rather than Florida's own experience with a competitive market approach (see 4 (a)).

c) Support development of a model consent decree to assist litigants when the outcome of the current Medicaid lawsuit is determined.

5. Surveillance:

Facilitate Florida's statewide participation in the Basic Screening Survey (BSS) to obtain data on oral health status and dental care access data for monitoring *Healthy People 2010* objectives (the BSS is part of the CDC's National Oral Health Surveillance System.)

Section II: Detailed Analysis

Background

Opportunities to improve oral health and access to dental care for vulnerable children in Palm Beach County and Florida are manifold. They are inherent in existing Medicaid and Child Health Insurance (CHIP) legislation, regulation, and administrative policies. Because Medicaid and CHIP are state-managed programs that operate with federal support and under federal regulation, each state's programs are unique. This report relies substantially on examples of progressive policies implemented by other states and locales in suggesting options for FL and PBC.

Additional federal legislation and resultant programs also provide options and opportunities for the State and County. The American Recovery and Reinvestment Act of 2009 (ARRA, aka "The Stimulus Bill") creates a Health Information Technology program for Medicaid providers that is now in development. The federal "Grants to States to Support Oral Health Workforce Activities" program was reauthorized in 2008 and will be re-competed at HRSA in 2011. Under close Congressional review by the Domestic Policy Subcommittee of the House Committee on Oversight and Government Reform, the Centers for Medicaid and Medicare Services (CMS) is actively attending to dental performance in Medicaid and CHIP. As a result, additional opportunities to improve public dental programs are anticipated. Both House and Senate final healthcare reform bills mandate pediatric dental coverage within the proposed exchanges initially and then applied to all public and private plans later.

This section provides background for understanding the problem and offers a range of policy options for consideration by the Florida Public Health Institute (FPHI) in its efforts to improve the situation. Suggested options build upon findings of investigations conducted by the Children's Dental Health Project (CDHP) that included key informant interviews, review of documents and publications, federal and state data, a provider survey, a webcast prepared for FPHI, and additional sources.

Problem Statement

Viewing the oral health status of children in Palm Beach County (PBC) and in Florida through a broad lens, Florida's children are much like children in the rest of the nation. Tooth decay remains the most prevalent chronic disease of childhood and its distribution reflects profound disparities by income, race/ethnicity, insurance status, family structure, special healthcare needs, parental education, geography (rurality), and social condition (migrant, immigrant, homeless).

Many of PBC's children fall into these high-risk groups. Among the approximately 275,000 County children ages birth to 18, roughly 80,000 are under age six, the age at which Early Childhood Caries (ECC) becomes expressed. According to the 2000 US Census, one-in-six PBC children lives in poverty (n=44,000) and the county's overall population is significantly minority

(18% Latino, 16% Black) and ethnic (22% speak a language other than English at home; 17% are immigrant), although somewhat less so than the overall State.

PBC has a smaller percentage of its population living in poverty (10.2%) than does Florida (12.1%) or the US at large (13.0%). But the proportion of low income children is substantial. The Palm Beach Post newspaper reported in June 2009 that 47% of all children in the County school system qualified for free or reduced-cost lunch, a proxy for Medicaid and CHIP eligibility, and that the numbers were expected to increase later in the year. With an October 2009 public school enrolment of 171,282 (Sun Sentinel October 21, 2009), roughly 85,000 County children are eligible for free or reduced meals.

Applying national pediatric dental epidemiologic rates to the County, it is estimated that at least 20-25,000 County children under age six have experienced tooth decay and that at least 15,000-18,000 have untreated disease. The majority of these children are minority and living in poor or near poor families and are eligible for one of Florida's various Medicaid and CHIP programs, all of which offer robust dental coverage.

These PBC children remain overwhelmingly underserved as CDHP's investigations confirmed. In calls to 323 of the County's 337 general, pediatric, and orthodontic practices seeking a dental appointment for a child in Medicaid, only 7 of 285 general dentists (2%), 5 of 19 pediatric dentists (26%), and 4 of 33 orthodontists (12%) accept a new Medicaid-insured child as a patient. Children in CHIP are slightly better served as 16 additional dentists participate in CHIP but not Medicaid (7 general dentists, 3 pediatric dentists, 6 orthodontists). Overall, only one-in-13 primary care dental practices in PBC accept children with public insurance coverage. Almost all of these few providers accept children in Medicaid who also have special healthcare needs. Even if every general and pediatric dentist in the County were to participate equally in Medicaid and CHIP, each would need to serve approximately 200 more school aged children.*

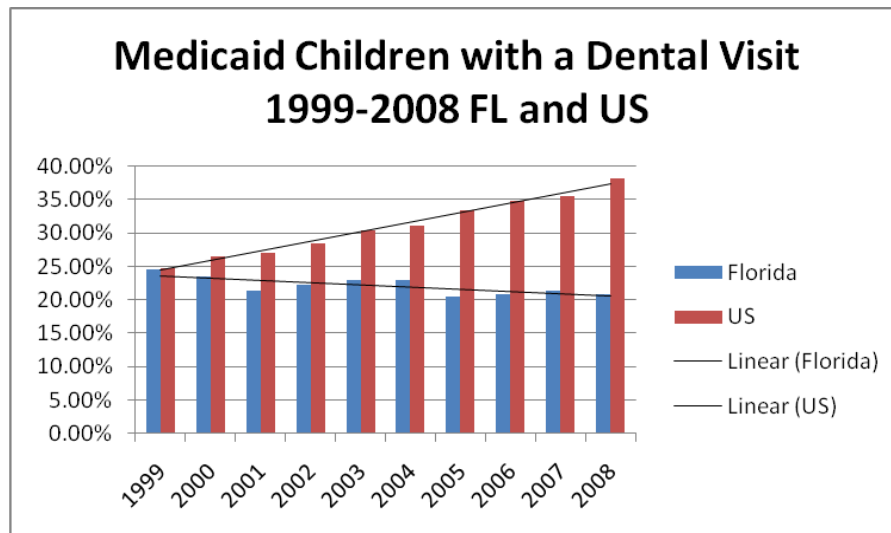
Parents of covered children would have significant difficulty identifying the few dentists who are providers as FL has not yet complied with a federal requirement to list dentists who participate in Medicaid and CHIP on the www.insurekidsnow.gov public website. A call to the County Dental Association would also be unhelpful as the respondent there erroneously reported that only one County dentist participates in Medicaid and none was identified as a CHIP provider. Of the offices contacted that do not participate in Medicaid and CHIP, only 69 of more than 300 offered a name of an office that does participate but fewer than half (n=33) of those referrals accurately identified a participating provider.

The dental safety net for children in Medicaid is also very limited. CDHP's inquiry identified three health centers in PBC that accept children in Medicaid but not CHIP, one that accepts children in CHIP but not Medicaid, two that accept *some* Medicaid and CHIP plans, and one that

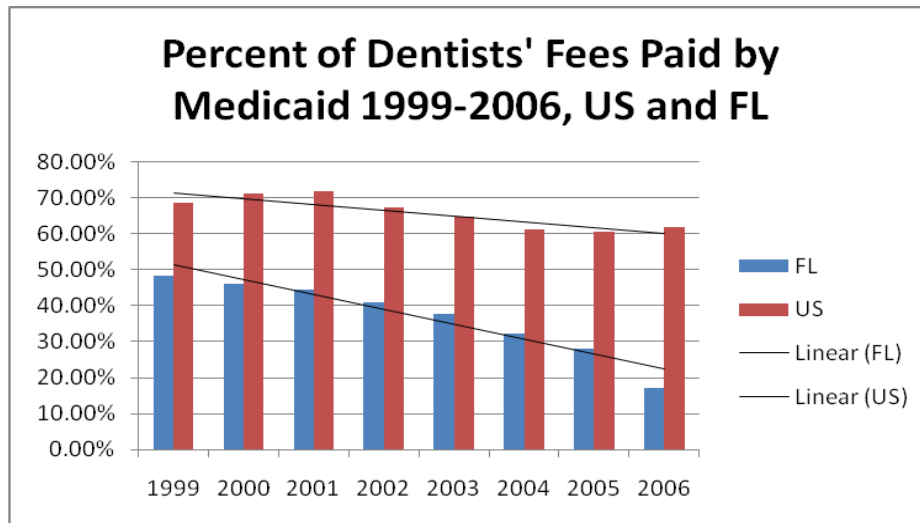
* Using free and reduced lunch as a proxy for Medicaid and CHIP eligibility, there are roughly 85,000 PBC school-aged children eligible. One-fifth currently receives care (statewide) leaving 68,000 to be cared for by the 304 general and pediatric dentists in the County. This calculation does not include children under age six.

does not provide dental services to children in either program. All that do provide dental services reported wait times of three-to-six months for appointments. This finding is unexpected as health centers benefit from providing care to populations with dental insurance coverage that provides a reliable source of clinic income. Given that FL’s adult Medicaid program provides for only emergency services that relieve pain and infection, health centers would improve their income stability by expanding services to children in Medicaid and CHIP.

As a result of the paucity of dentists participating in Medicaid, FL ranks near last among states in the proportion of children reported to have a dental visit paid by Medicaid. During the reporting years 2005-2008, FL ranked lower than 46 other states (48th in 2005, 49th in 2006, 47th in 2007, and 48th in 2008). Nationally, rates of Medicaid utilization have been increasing over recent years while in FL they have been declining (Figure below). Since 2005 only 21% of enrolled children in FL have had any dental visit in a year, 13% have had a preventive dental visit, and 8% have experienced dental repair.



Florida’s low performance reflects extremely low payment rates to dental providers as substantiated in a CDHP study that compares the aggregate of each State’s Medicaid fee schedule for 10 common pediatric dental procedures with rates charged by dentists to commercial insurance carriers for the same services. While managed care contracting is not considered in that analysis, managed care vendors tend to set fees at levels that parallel state Medicaid fee schedules. FL ranked as the lowest paying state for which data were available in each year 2000-2006 with only the District of Columbia paying lower rates in four of those years. (Numbers of states were 41 in the 2000 analysis, 42 in 2001, 43 in 2002 and 2003, 44 in 2004, 45 in 2005 and 2006.) The chart below illustrates that payment rates as a percentage of usual fees has declined steeper and faster in FL than for the national as a whole.



Low payment to providers is central to recommendations provided in this report. While adequate payment is not a sufficient condition to ensure that care is available, it is a necessary condition. For this reason, few of the policy recommendations made in this report can gain traction or result in markedly improved access to dental services unless payment levels are dramatically improved.

This need is being addressed through the courts. A class action lawsuit, currently in trial in the U.S. District Court for the Southern District of Florida, was brought by medical groups who allege that FL has failed to meet federal Medicaid (Title XIX of the Social Security Act) regulations that require preventive care for Medicaid children, including dental care by a dentist. Federal law specifies that children eligible for Medicaid must be provided services comparable to services for children who are covered by private insurance in the same geographic area.

If the plaintiffs prevail—and assuming that the terms of the declaratory and injunctive relief sought by plaintiffs can be successfully implemented—the lawsuit could be transformative for Medicaid-eligible children in the State. However, the lawsuit remedy will hinge on increased payments to providers at a time when Medicaid roles are up and state income is down due to the recession. This will create a revenue-generating challenge for the state legislature. For this reason, one of the policy options included in this document is a proposed industry fee on soda and other sugar-sweetened beverages, with funds earmarked for Medicaid program fee enhancement and sustainability. This approach would both generate revenue and highlight the role of simple sugars in the pediatric caries epidemic.

In sum, too many of Florida's children suffer too much, too early in life, from a disease that is overwhelmingly common (44% of US children have visible cavities at age 5) yet also preventable through diet and fluoride management. Significantly, dental caries is progressive and its experience early in life is the best predictor of lifelong tooth decay. With preventive care being far less costly than reparative care and early childhood being the highest risk time for caries to

become established, the greatest return on investment can occur through early preventive interventions. There are many policy options available to FL and PBC policymakers to address both improvements in oral health and dental care for vulnerable children.

Current Dental Coverage Policy

Florida's current publicly funded health insurance program for children is comprised of a complex mix of programs for which eligibility varies by child age and family income (figure below). Each component of the program provides comprehensive dental coverage that is identical across the various components (see Dental Benefits Coverage by Age and Income at <http://sites.google.com/site/fphicdhp/medicaid-chip-dental-plans-tbf--1>).

However, the CHIP plans cap the dollar value of dental benefits at \$1000 annually. This approach is cost-saving to the state but of direct harm to the child-beneficiary as pediatric dental procedures are by nature not elective. As such, savings come at the cost of insufficient treatment for the child and frustration at not being able to provide needed care by the few dentists who do participate.

This cap (if it is still in place) is inconsistent with federal CHIP Reauthorization legislation signed by the President on 2/4/09 that requires states to provide dental coverage that is "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." An official "Dear State Health Official Letter" issued by Cindy Mann, Director of the federal Center for Medicaid and State Operations on 10/7/09 (SHO #09-012, CHIPRA #7, page 9), states that cost sharing for the required benefit must be limited in aggregate for both medical and dental care of targeted low-income children to 5% of a family's income. The letter further specifies that cost-sharing required by benchmark plans that qualify a state's CHIP program are not applicable to the CHIP program. In short, the State is required to provide the full dental benefit to a child, even if the cost to the state exceeds \$1000 in a year, with cost sharing by the parent that is markedly limited.

The complexity illustrated below not only causes confusion among parents (many of whom have limited education and literacy skills) but makes it more difficult to find a participating provider as dentists can elect to participate in some or all of these programs. For example, a parent of three children ages 1, 3, and 5 with family income between 133% and 185% of the federal poverty level may be involved with three different programs and multiple dentists. Adding to the complexity, the program is administered through a variety of managed care vendors and few dentists in PBC participate in all such plans.

| | Poor | Near Poor | Working Poor | | Not Poor |
|--------------|-------------------------------|-----------------------------------|--------------|--------------|-------------|
| | 0-100% FPL | 100-133% FPL | 133-185% FPL | 185-200% FPL | 200% + FPL |
| Ages 6-18 | Medicaid For Children (EPSDT) | Healthy Kids (Novel CHIP) | | | HK Self Pay |
| 5 Year Olds | | | | | |
| Preschoolers | | Medi Kids (CHIP/EPSDT Look-Alike) | | | MK Self Pay |
| Infants | | | | | |

In short, the program appears to have been designed to maximize utility for the state while creating complexities for the beneficiary and provider. One simplified option is portrayed in the figure below which additionally incorporates inclusion of populations with higher incomes. Ideally, the CHIP program would be administered as a Medicaid expansion so that the comprehensiveness, stability, and cost-sharing limits inherent in Medicaid are extended to all low and modest income families.

| | Poor | Near Poor | Working Poor + | | Not Poor |
|--------------|-------------------------------|--------------|----------------|--------------|---------------|
| | 0-100% FPL | 100-133% FPL | 133-185% FPL | 185-300% FPL | >300% FPL |
| Ages 18-21 | Medicaid For Children (EPSDT) | CHIP | | | CHIP Self-Pay |
| Ages 6-18 | | | | | |
| 5 Year Olds | | | | | |
| Preschoolers | | | | | |
| Infants | | | | | |

While this report focuses on children, it is notable that FL is among 21 states that provide either no adult dental coverage in Medicaid (n=6) or emergency services only (n=15). At a minimum, states should provide sufficient coverage to allow stabilization of the dentition for all adults and comprehensive dental services for women while pregnant and for at least 60 days after delivery.

Given the profound mismatch between dental system capacity and vulnerable children in need of dental services, federal and state policymakers as well as dental organizations are considering significant workforce changes. These include expansions of practice scope for existing “midlevel” dental providers—dental assistants and dental hygienists—as well as development of new dental providers, including the “Community Dental Health Coordinator” proposed by the American Dental Association, the “Advanced Dental Hygiene Practitioner” proposed by the American Dental Hygienists’ Association, the Alaska Dental Health Aid Therapist, and the Minnesota Dental Therapist.

With support from the WK Kellogg Foundation, a national effort is underway to promote the implementation of Dental Therapists in the US. These therapists are already well established internationally, including in some countries with dental systems as advanced as the US (Great Britain, The Netherlands, Australia, and New Zealand). Dental therapists provide a range of preventive and restorative pediatric dental treatments that meets most children’s needs. (CDHP’s report, executive summary and policy brief on therapists is available at cdhp.org) Implementation of dental therapists in the US requires modification of state practice acts. The current political feasibility of modifying FL’s practice act to implement dental therapists is considered by key informants to be very limited.

Policy options

1. Enhance lawsuit impact

- a. Amicus Brief: Support development of a “Brandeis *amicus* brief” to US District Judge Adalberto Jordan that provides scientific evidence useful in resolving the current lawsuit, specifically by promoting (1) caries prevention and disease management approaches that hold promise to reduce disease burden at lower costs and (2) fee levels that reflect the dental marketplace.
- b. Model Consent Decree: Convene a group of dental Medicaid and legal experts to develop a model Consent Decree for the parties’ consideration so that “lessons learned” from prior lawsuits in other states can be incorporated into a meaningful FL settlement.

2. Increase provider participation

- a. Expand private dentists’ participation: Assuming that the lawsuit results in sufficient fee increases and other “fixes” to program administration (see 3.a. below), develop and implement a series of activities that address root causes of dentists’ lack of participation. These causes include issues of stigma, comfort and competency in care of children, and normative values of dentists in PBC. These root causes can be addressed through a variety of approaches that include
 - i. establishing a local study club for dentists to enhance pediatric dental treatment knowledge, explore cultural competencies, share experiences, learn from active providers, establish mentor-dentists for new providers, meet covered families and program officials, train office staff, and promote understanding of business practices appropriate to the population (“doing well by doing good”) (exemplar: none known);
 - ii. linking Medicaid participation to volunteer programs such as Give Kids a Smile, Mission of Mercy, and Donated Dental Services, e.g. through vouchers (exemplar: Jeff Dalin’s program in Missouri);
 - iii. establishing a “share the care” program with the PBC Dental Society supported by case management (exemplar: Tomkins County NY Program)
 - iv. contracting private dentists to FQHCs as now allowed under federal statute (exemplar: CT Health Foundation handbook and model contract)
 - v. instituting a “Dental Home” program with local Head Start and Early Head Start (exemplar: AAPD HS/Dental Home Initiative).
 - vi. matching small subsets of children to local dentists who have individual interests in particular conditions in order to establish niche dental homes, e.g. by age (preschoolers, adolescents); social condition (foster children, homeless children), or health condition (children with medical, developmental, mental special needs). (exemplar: none known)
 - vii. creating a program for dental students to visit the offices of dentists who are actively engaged in caring for children in Medicaid.

Dentists who become engaged can be encouraged to be emissaries to other dentists and can be provided with social rewards (e.g. plaques, press coverage, dinners, testimonials from parents etc)

b. Enlarge the dental safety net:

- i. Support technical assistance to health centers that increases their efficiency and adjusts their patient mix to include more children in Medicaid and CHIP (exemplar: DentaQuest Institute's *Safety Net Solutions* program).
- ii. Consider options to "grow" the safety net through public-private contracting, school-based dental programs, and/or development of off-site pediatric dentistry and/or Advanced Education in General Dentistry residencies through Nova Southeastern or University of Florida dental schools (with potential start-up support from HRSA).

3. **Improve Medicaid/CHIP programs**

- a. Simplify Administration: Since 2005, FL's Agency for Health Care Administration has operated its Medicaid program under an "1115 Research and Demonstration Waiver" in a limited number of counties. Further expansion has been curtailed by the legislature. Reform objectives were to reduce the rate of spending growth while testing new market approaches that promote consumer choice and competition among private health plans. This approach has led to the complexity described above including a multiplicity of dental plans. In recent years, progressive states have moved away from this "competitive market" approach and substituted a simplified approach that is transparent and seamless. This has been accomplished, for example in TN, VA, CT, and MA by carving out dental from medical MCO plan responsibilities, contracting with a single dental vendor, exempting the vendor from financial risk for increased utilization, simplifying paperwork including reductions in prior authorization requirements, requiring beneficiary assistance in making and keeping dental appointments, enhancing reporting, establishing a communities-of-interest advisory and oversight board, and offering dental providers market-responsive fees.
- b. Simplify Coverage: As described, FL's Medicaid and CHIP responsibilities are administered through a variety of programs and vendors that creates complexity and confusion among parents and providers and exacerbates the provider shortage problem. Since CHIP Reauthorization now significantly mutes differences between CHIP (Florida Healthy Kids) and Medicaid by eliminating the annual dollar cap on services, the State can consider replacing MediKids (a CHIP Medicaid look-alike) and Healthy Kids (a CHIP novel plan) with either a consolidated CHIP plan or a new Medicaid expansion. This simplified coverage would eliminate differences by child age or family income and allow the development of a robust network of dental providers who accept all children in FL's public insurance plan.

- c. Expand coverage:
 - i. Medicaid: Current Healthcare Reform legislation would require all states to expand Medicaid coverage to at least 133% of the federal poverty level (FPL). FL currently covers to 185% for children under age one, to 133% for 2-5 year olds, and to 100% for children six years and older. Forty states currently cover all children to at least 133%. Oral health coalitions can advocate for expansion of Medicaid coverage to at least 133% FPL.
 - ii. CHIP: CHIPRA allows states to expand coverage to 300% FPL with federal match rate higher than for Medicaid. FL currently covers children under age five in MediKids (an EPSDT Look-Alike) and older children in Healthy Kids (CHIP). Oral health coalitions can advocate for coverage to 300% FPL for all children whose families' incomes exceed Medicaid eligibility.
- d. Maximize administrative match: CMS provides an enhanced match (CMS funds at three federal dollars for each state dollar expended on administrative services, i.e. 75% federal match in Medicaid and, in FL, in CHIP) that can be used for translation, transportation, appointment assistance, and other facilitating services. To be further explored is the potential for case management services (see item 1.a.iii above) utilizing a social worker or health educator to coordinate dental care among PBC participating dentists. This approach holds utility for reducing cancelled and missed appointments and in encouraging dentists' participation in Medicaid and CHIP.
- e. End the Miami-Dade Dental Demonstration: or prevent it from expanding to PBC: This capitation demonstration has been studied and found after four years to be ineffective in that it serves fewer children at a higher cost per child served (\$233 in CY2007 versus \$191 per child served prior to the "cost-savings" demonstration in FY 2003). FPHI can promote dissemination of analytic information to communities of interest so that opposition to expansion is robust.
- f. Update EPSDT periodicity schedule: The FL Child Health Check-Up (FL's EPSDT screening program) website states that dental referrals are made at age 3. Oral health coalitions can encourage ACHA to update that referral to age one to be consistent with current recommendations of the American Academy of Pediatric Dentistry in conjunction with preparing dentists and physicians to implement that change.
- g. Fix CHIP Cap: If MediKids and Healthy Kids continue to cap dental benefits at \$1000/year, they are out of compliance with current federal regulation. The cap should be eliminated. FPHI can promote the cap elimination by highlighting this issue for ACHA.
- h. Plan to implement the "CHIP wrap": CHIP reauthorization establishes a state option to provide dental coverage through CHIP for those income-eligible children who

have employer-sponsored medical coverage but no dental coverage. In anticipation of an improved economic climate wherein such a “wrap” can be seriously considered by FL policymakers, FPHI can apply CMS regulation of the wrap to the situation in FL, calculate the approximate number of eligible children, model the potential cost, and prepare advocates to support implementation. While a number of states have expressed interest in this option, only Iowa has developed legislative language to create such a program.

- i. Promote Public-Private Contracting: CHIP reauthorization explicitly prohibits states from preventing an FQHC “from entering into contractual relationships with private practice dental providers in the provision of FQHC services” and thereby creates an opportunity for FQHCs to expand capacity through public-private partnerships. A description of how this is accomplished, along with a model contract for implementation, is currently in finalization by CDHP with support from the California Healthcare Foundation. FPHI can develop and implement a campaign to engage in this practice.
- j. Comply with Insure Kids Now: CHIP reauthorization requires that since August 4, 2009, states must list on a public website (www.insurekidsnow.gov) “a current and accurate list of all such dentists and providers within each state that provide dental services to children enrolled in [Medicaid or CHIP].” FL is out of compliance with this requirement as it has not posted an entry on the website. CMS and child advocates are aware of the many listing errors in many of the compliant states and is actively seeking suggestions to improve this reporting. FPHI can work with ACHA to establish a PBC demonstration detailing a method to ensure accurate reporting.
- k. Implement CHIPRA new parent education program: CHIP reauthorization establishes a new parent education requirement that requires payers of birth services under Medicaid and CHIP to deliver “oral health educational materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit with their newborn’s first year of life.” FPHI can instigate development, evaluation, and refinement of such materials in PBC in a way that can establish a model for the country.
- l. Cover pregnant women: Using evidence in support of perinatal oral health care assembled by the New York State Department of Health (and soon to be replicated by the State of California), FPHI can actively campaign for an adult Medicaid dental benefit for pregnant women modeled on the benefit in CA. (see <http://cdhp.org/system/files/ShiftingParadigms.pdf>)
- m. Use XIX money (CA) for “oral health services initiatives”: According to CMS, CA uses CHIP funding for “oral health services initiatives” for children under age five that include “case management, oral health education, innovative preventive services, and mobile vans that provide dental services.” FPHI can develop a series of options

for ACHA's consideration to utilize CHIP funding to address determinants of poor oral health and advance primary prevention and disease management.

- n. Prioritize the oral health of young children: Various approaches that have been demonstrated in other states hold strong promise for low-cost/ high-yield improvements through prevention. Programs that FPHI can promote include:
 - i. Rhode Island's Medicaid reform that pays "full market rates" for the dental care of children initially under age five and now being expanded to include that cohort as it ages;
 - ii. New Jersey's early referral demonstration that pays pediatricians a modest bonus for successfully implementing referrals of young children to dentists after providing counseling and preventive services in office (see below under prevention);
 - iii. Washington State's Access to Baby and Child Dentistry Program and its spinoffs that pay dentists higher rates under Medicaid if they have first completed a course in infant oral health;
 - iv. North Carolina's Into the Mouth of Babes and its spinoffs that reimburse pediatricians to provide screening, counseling, fluoride varnish application, and referral of young children to a dentist.

- o. Create Medicaid interstate portability: A PBC population of special interest is its migrant farm workers and their children as PBC has the highest number of migrant and seasonal farm workers (MSFW) of any FL county, nearly 200,000 in 2000 or 11% of all FL MSFWs. Modeled on an interstate provider network developed between MI and TX, FPHI can encourage ACHA to enter into a Medicaid portability arrangement with NC that would allow continuity of dental care as families relocate between these two states. To target young children at risk for dental disease, FPHI can additionally develop messages for parents of children in Migrant and Seasonal Head Start that explain how to access care during relocations.

- p. Prepare for ARRA HIT Opportunity: CMS is currently developing the Health Information Technology program authorized by ARRA for Medicaid providers. Health Centers qualify for HIT grants as do private dentists whose patients are at least 30% publicly funded. FPHI can partner with NORC (Cheryl Casnoff) and CDHP in convening an expert group to anticipate and plan for application of these new HIT funds to dental practices that serve children in Medicaid.

4. **Promote prevention**

- a. Engage primary care medical providers (see also option n.): Because the onset of dental caries as a disease process occurs before age two and few parents consult dentists about their infants' oral health, primary care medical providers who care for children are well positioned to provide screening, counseling, fluoride varnish, and referral services. FPHI can capitalize on physician training efforts by many states (e.g. CT, SD) and professional organizations (e.g. American Academy of Pediatrics and

American Academy of Family Practice) to develop and implement a campaign that engages primary care medical providers in PBC.

- b. Develop caries management protocols: In recent years, dental researchers (with substantial support from NIH) have investigated approaches to improving children's oral health through biological and behavioral interventions. Some of these approaches were highlighted at a CDHP-Columbia University-New York Academy of Sciences convocation (<http://www.nyas.org/Events/Detail.aspx?cid=e8cbbd75-6271-4698-bc1c-cc98d69184c3>). Needed is convocation of researchers, together with clinicians, policymakers, and payers to explore implementation of these interventions and to translate research findings into pragmatic policies, procedures, and practices. FPHI can facilitate the translation of science into practice by convening such a caries management event and supporting demonstrations in PBC based on expert findings.
- c. Dental Home initiative: Iowa's Oral Health Bureau Director, Dr. Bob Russell, has developed and implemented a unique approach to establishing a dental home for all children in its Medicaid program (see <http://www.ismiledentalhome.org/>). In addition to facilitating a "dental home" with a dentist, physician, nurse, or other healthcare provider, the program seeks to "improve the dental Medicaid program, recruit and retain dentists in underserved areas, incorporate dental clinics within rural hospitals, and improve the dental support system for families." FPHI can evaluate the potential of this creative program for tailoring to PBC.

5. **Expand dental workforce**

- a. Expand "dental midlevels" scopes of practice: FPHI can clarify for policymakers the current strictures on dental hygienists and dental assistants in comparison with other more progressive state practice acts and can promote the expansion of dental functions by these existing members of the dental team.
- b. "Direct Access for Dental Hygienists": FL is currently considering legislation (S490) that would allow delegation of specified dental hygiene services in "health access settings" under "public health supervision" rather than "general" or "direct supervision." FPHI can promote this effort by convening communities of interest, assembling information on direct access impacts in other states, and informing the debate. Additionally, FL can replicate other states, (approximately 12 states including those as disparate as OR, KS, WI, PA and VT) by allowing dental hygienists to provide sealants in schools and other proscribed public health settings. The most progressive variation of this authority allows hygienists to select teeth for sealant application without an examination by a dentist.
- c. Explore dental therapy: Dramatic increases in dental system capacity for low-income children can be realized only through major changes in dental workforce, specifically implementation of the dental therapist. FPHI can lay the groundwork for dental

therapy in FL by informing policymakers and communities of interest about this option, by monitoring and reporting on experiences in other states, and by collaborating with a range of other interests.

6. **Raise revenues:** Paying for Medicaid and CHIP improvements will demand new sources of income for the state. One option is to raise earmarked revenue through an industry fee on soda and other sugar-sweetened beverages. Efforts in IL and ME can inform this approach as can review of State Representative Juan Zapata's 2006 effort to ban soda sales in FL schools. FPHI can organize an effort to tax soda by reviewing prior efforts in other states for "lessons learned," modeling potential revenues, analyzing political feasibility, convening proponents, and managing an organized approach.