Many Americans lack access to basic, affordable oral health care. Tooth decay is the most preventable unmet health need in the United States, yet one-quarter of children have tooth decay before they enter kindergarten and one-third of adults report having it. Growing evidence links oral disease to chronic health conditions such as diabetes, heart and lung disease and potential pregnancy complications. Costly for families, communities and states, untreated tooth decay can lead to pain and infection, missed school days, and problems with eating and speaking. Dental expenses for U.S. children ages 5 to 17 were about $20 billion in 2009—almost 18 percent of all health care costs for this group.

In sum, tooth decay and unaddressed oral health problems add up to poor health outcomes and rising health care costs. Emergency room (ER) visits for preventable dental conditions cost $1.6 billion in 2012, and the cost of a procedure, such as a tooth extraction, can increase nearly 10 times when performed in
POLICYMAKERS CONVENE TO SHARE CHALLENGES AND POLICY OPTIONS

More than 50 legislators, legislative staff, providers and others convened at NCSL’s Legislative Summit in August 2015 to discuss state options for improving oral health care and reducing costs for all populations. The session, “Smart Investments in Oral Health: State Policy Options for Improving Care and Reducing Costs,” featured national expert Andrew Snyder from the National Academy for State Health Policy. Snyder highlighted initiatives that address oral health coverage, integration of oral health with primary care, innovations in oral health care delivery and public health strategies. According to Snyder, oral health is an important issue for state policymakers for the following reasons:

- Oral disease is preventable, but is highly prevalent and chronic.
- Significant disparities exist among groups in the U.S., and there are long-standing, persistent barriers to low-income people accessing care.
- 108 million Americans lack dental coverage.
- Poor oral health has potential negative effects on development, nutrition, education, employability and quality of life.
- Oral disease has been linked to avoidable emergency room visits and has connections to systemic conditions like cardiovascular disease, stroke, and diabetes.

Missouri Representative Susan Allen and Kentucky Representative Thomas Burch shared challenges and oral health initiatives in their states. In Missouri, for example, Representative Allen pointed to provider shortages, especially in certain geographic areas, and costly visits to the hospital emergency room for unaddressed oral health needs. In 2013, nearly 60,000 emergency department visits were due to tooth and jaw disorders and other dental problems. There, patients receive treatment that addresses the symptoms of pain, not the underlying causes, which could be better addressed in the dentist’s office, Allen said. The trend is costly to the state: Dental emergency department (ED) visits cost about $300 per visit and totaled $17.5 million in 2013. Expanding access to preventive services results in a positive return on investment, she concluded. Other speakers and attendees shared policy options that address unmet needs and improve oral health outcomes. Many of these examples are featured throughout this brief.
an emergency room instead of a dental office. These factors are costly for states and affect the quality of life for individuals and families.

Concerned about these cost and health status trends, policymakers have adopted myriad strategies to improve oral health for children and adults. This report highlights targeted state policy options for improving oral health for children and adults, as well as system-level reforms to improve care and reduce costs for all populations.

STATE OPTIONS FOR IMPROVING CHILDREN'S ORAL HEALTH

Tooth decay is more prevalent among children from lower-income families and children of certain racial and ethnic groups, according to the Centers for Disease Control and Prevention (CDC). Total U.S. dental expenditures for children up to 21 years old exceeded $25 billion in 2012, placing a significant financial burden on state budgets. According to a 2013 report from The Pew Charitable Trusts, annual Medicaid spending for dental services is expected to increase by 170 percent—from $8 billion in 2010 to $21 billion in 2020. State legislators have adopted numerous strategies to improve oral health practices and care for children.

Assess and Screen in Primary Care Settings

Pediatricians are often the first medical providers to examine a baby or toddler’s mouth. By the age of 6 months, oral health screenings should begin and continue as a routine part of every doctor’s visit, according to the American Academy of Pediatrics. The American Academy of Pediatric Dentistry (AAPD) recommends that a child go to the dentist by age 1. The federal Health Resources and Services Administration (HRSA) established the Bright Futures Guidelines in 1990 to improve the standard of care for children and adolescents. Since 2002, the American Academy of Pediatrics (AAP) has overseen development and dissemination of these guidelines. The majority of states use the recommendations in Bright Futures to guide which services the state Medicaid program covers.

Bright Futures offers pediatric care providers and families tools for evidence-based care for children from birth to age 21. For example, oral health risk assessments are recommended at the 6- and 9-month well-child visits with primary care providers. A pediatrician can identify conditions like plaque, cavities or inflammation of the gums, and also refer a patient to a dental provider. Oral health risk assessments provide early tracking for a child’s oral health history that can be later referenced by his or her future dental provider. Early evaluation can help maintain good oral health and prevent or treat disease.

Applying fluoride varnish is another way pediatricians and primary care providers can help with preventive oral health procedures. States have now begun reimbursing doctors through Medicaid. According to The Pew Charitable Trusts, most Medicaid programs pay between $15 and
$30 for the procedure. Fluoride varnish can reduce the rate of tooth decay by one-third, leading to significant cost savings, such as avoiding restorative dental care or hospital visits.7

**School-based Prevention and Care**

Most dental disease can be prevented by early identification and intervention with care such as dental sealants and fluoride treatments. Sealants—plastic coatings applied to vulnerable molars—help prevent decay and may save money by preventing the need for dental-related emergency room visits and other costly dental care. Not all policymakers embrace sealant programs, and some concern exists about the safety of sealants; however, one-time application of sealants has not been found to provide chronic exposure, and applying them properly reduces exposure. Based on a review of evidence about sealant safety and risks, the Association of State and Territorial Dental Directors recommends sealants for all children. Dental sealants
applied in school-based programs reduce tooth decay by as much as 60 percent. They also can reduce dental health disparities and lead to follow-up care and enrollment in health insurance. The U.S. Preventive Services Task Force rates school-based sealant programs as an evidence-based approach for reducing tooth decay. The task force evaluated four sealant delivery programs in 2013 and found that sealants reduced tooth decay up to 48 months after application. In-school sealant programs also help raise awareness about healthy oral hygiene for children who do not regularly visit a dentist.

School sealant programs exist in most states and vary in scope, complexity, funding methods and other factors. According to a 2013 report by The Pew Charitable Trusts, successful sealant programs target high-need children, use a cost-efficient workforce, and eliminate reimbursement and regulatory barriers for providers. Some programs arrange to apply sealants at school-based clinics or in mobile vans, while others link schools to private dental practices where children can receive the services. Policymakers have taken steps to expand access to and reimburse for sealant services and providers. Laws in several states allow dental hygienists and assistants to apply sealants in schools or other public health settings. These policies expand access to preventive services, especially for underserved children and adolescents.

- Arkansas lawmakers created a collaborative care program in 2011 that allows qualified dental hygienists—who collaborate with consulting dentists—to provide sealants and other procedures in public health settings.
- Colorado lawmakers established a grant program in 2013 to support school-based dental sealant programs, community water fluoridation and other strategies.
- A 2009 Massachusetts law authorized public health dental hygienists to provide sealants and certain other preventive services without a dentist’s prior examination. The law also allows reimbursement under Medicaid and the Children’s Health Insurance Program (CHIP).

Raise Awareness About Healthy Behaviors

Around 80 million Americans have limited health literacy—the ability to understand and interpret health information—which puts them at greater risk for lacking access to care and having poor health. People with poor health literacy are more likely to have fewer preventive procedures, potentially leading to costly ER visits or chronic health conditions. This group can include older...
adults, people with limited education and those with limited English proficiency. Some states have launched oral health campaigns to spread awareness like Delaware’s “Healthy Smile. Healthy You.”

STATE OPTIONS FOR IMPROVING ADULT ORAL HEALTH

Poor access to dental services has economic consequences for states. Visits to the emergency room for dental reasons cost $1.6 billion in 2012 and rarely addressed the underlying condition. Estimates show that 79 percent of these patients could have been treated in a community setting.\(^1\)

Medicaid is a major payer of these costs. Case in point: 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.\(^2\) 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.\(^3\)

Expand Coverage for Low-Income Adults

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 through state Medicaid programs.\(^4\) An estimated 800,000 will gain coverage through the state or federal health insurance exchanges. According to a February 2016 report from the Center for Health Care Strategies, 46 states and the District of Columbia currently cover at least emergency dental services (e.g., relief for uncontrolled bleeding or trauma) for adults with Medicaid; of those, 13 states cover emergency care only, 18 states and the District of Columbia cover certain limited services (such as preventive and restorative procedures), and 15 states offer extensive coverage to their base Medicaid adult population.
Several states have restored adult dental coverage in recent years, after eliminating them during the economic recession. A 2014 California law covers certain dental benefits for all adults on Medi-Cal (the state’s Medicaid program). In 2014, Idaho lawmakers reinstated dental benefits for adults enrolled in Medicaid, including coverage for routine exams and preventive and other dental services. Washington restored dental coverage in 2013 for Medicaid-enrolled adults to include restorative and preventive services, emergency services, root canals, cavity care, and routine checkups and cleanings.

Some states are providing preventive dental benefits to adults for the first time. In 2013, Colorado lawmakers passed Senate Bill 242, which provided dental benefits to all adult Medicaid enrollees, with up to $1,000 in dental benefits each year. South Carolina will cover cleaning, fillings and extractions for adults with very low incomes or disabilities.

Expand Oral Health Workforce

States struggle to find an adequate number of oral health providers who accept Medicaid. Dentists often decline to participate in Medicaid because of lower reimbursement rates than in the commercial market. According to the American Dental Association (ADA), 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. Some states have adopted financial and other incentives—including enhanced reimbursement or reduced administrative burden (less time filling out forms)—to increase the number and availability of oral health providers who are willing to provide care to Medicaid patients. States also have taken steps to increase the capacity of the existing oral health workforce to meet demand by, for example, using telehealth (providing ser-
vices remotely) or changing provider roles and practice settings. California lawmakers passed legislation in 2014 to reimburse hygienists and dentists for telehealth dental services.

**Improve Oral Health Access for Pregnant Women**

Dental disease in pregnant women is associated with pre-term birth, low birthweight and gestational diabetes, all of which can harm the baby and may result in a more costly pregnancy. Dental care is safe throughout pregnancy, although misapprehension about treatment safety and concerns about liability may cause dental professionals to delay treatment for pregnant women. In addition to the consequences of dental health problems during pregnancy, a woman’s oral health also can affect her children.

Pregnant women and young children often are more likely to see a primary care provider than a dental professional, so other providers such as obstetricians, gynecologists and pediatricians may be engaged in their patients’ oral health care. The New York State Department of Health created “Oral Healthcare During Pregnancy and Early Childhood: Practice Guidelines,” which pro-
vide screening and treatment recommendations for prenatal care providers, oral health professionals and child health professionals.\textsuperscript{16}

**STATE OPTIONS FOR IMPROVING ORAL HEALTH FOR ALL POPULATIONS**

Although some state policies are focused on specific populations, many states are taking steps to improve oral health for everyone through improved access to providers, improved systems of care and other overarching strategies described here.

**Ensure an Adequate Oral Health Workforce**

Even with new professionals entering the field—the number of dentists has slightly increased each year since 2001—some 49 million Americans live in a designated dentist shortage area.\textsuperscript{17} 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.

For example, many states expanded dental hygienists' licenses to allow greater scope of practice 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. Dental therapists typically are trained 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.\textsuperscript{18}

Eight states—Arizona, California, Montana, Minnesota, Oklahoma, Pennsylvania, Texas and Wisconsin\textsuperscript{19}—are piloting another new type of provider, Community Dental Health Coordinators (CDHC), who are trained by the American Dental Association. CDHCs are usually recruited from the same communities they serve and in addition to some basic, preventive services, may provide health education, connect patients with dental treatment, and arrange additional services such as transportation and child care.

**Coordinate Primary Care and Oral Health**

The connection between oral health 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.\textsuperscript{20} And on the medical side, almost all state Medicaid programs reimburse primary care doctors and nurses for providing oral exams, screenings and preventive services, such as fluoride treatments and parent education.

Several states have taken steps to integrate oral health into broader health system delivery reforms and to coordinate physical, mental, behavioral and oral health for individuals enrolled in Medicaid. For example, Oregon lawmakers passed House Bill 3650 in 2011 to create a new payment and delivery system known as Coordinated Care Organizations (CCOs). The state's 16 CCOs deliver physical, behavioral and oral health services to Medicaid enrollees.

**Expand Access to Providers through Teledentistry**

Telehealth can help achieve the goals of the triple aim—improving care and health while lowering costs—by improving access to appropriate, lower-cost services, such as timely primary or specialty care, or through lower-cost settings, including clinics, homes or workplaces. Telehealth adoption and expansion across the nation bring various challenges, some of which present policy questions for state leaders. For example, lack of broadband and cellular connectivity, and availability and affordability of devices for consumers and providers can hinder telehealth. The telehealth field is changing rapidly, and in some cases, technology may be
getting ahead of policy. Policymakers are working to craft frameworks that capitalize on the advancements and potential for telehealth, while maintaining an appropriate level of oversight to safeguard state investments and ensure effective health care delivery.

Teledentistry can leverage and expand the reach of the existing workforce. For example, 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. The project’s success led to a 2014 law including teledentistry as a specialty for Medicaid reimbursement. Arizona, California, Florida and New York all have some form of coverage of teledentistry in Medicaid.

Understand the State Role with Community Water Fluoridation

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, but especially for children whose adult teeth are still forming. The CDC estimates that every $1 invested in water fluoridation saves $38 in dental treatment. The decision to fluoridate the water supply is typically made at the local level and has met with resistance in some communities. A few states mandate fluoridation or regulate how the system functions. Twenty-six states and Washington, D.C., meet or exceed the average national percentage (74.6 percent) of citizens who get their drinking water from a fluoridated system. These rates vary and in 13 states at least 60 percent of the adult population does not have access to fluoridated water systems.

Maximize Current Data

Policymakers have enacted data and surveillance strategies that help them understand oral health challenges and unmet needs and develop targeted responses. For example, Colorado and Wisconsin use data to evaluate the effectiveness and efficiency of their school sealant programs as well as to allocate funding.

CONCLUSION

As the examples provided in this report suggest, there is not one singular strategy for improving oral health for children and adults. Instead, legislators are adopting a wide range of strategies aimed at addressing specific problems and removing barriers to good oral health care.
NOTES


9. Ibid.


12. Ibid.


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See more at: http://dentaquestfoundation.org.

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