

**Access to Oral Health Services for Low-Income People—  
Policy Barriers and Opportunities for Intervention for  
The Robert Wood Johnson Foundation**

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## **Executive Summary**

The National Conference of State Legislatures contracted with The Robert Wood Johnson Foundation (RWJF) in January 2002 to conduct a study of policy barriers to access to oral health care for low-income people and opportunities for the Foundation to address them. Over an eight month period, NCSL gathered and analyzed information, hosted meetings of national and state experts, and conducted site visits to five states (herein labeled States A through E). The site visits offer a rich portrait of the struggle to improve access in states and communities through conversations with nearly 75 people on all sides of the issue. Definite themes emerged from the site visits and the meetings about barriers that lead to three sets of opportunities for intervention by RWJF.

NCSL has documented multiple policy barriers to access to oral health services that are described in detail under the following sections:

- Supply, distribution and practice patterns of dentists
- Federal and state policy and programmatic barriers
- Dental education
- Research issues
- Leadership
- Advocacy, and
- Public education.

In general, it is much easier for people to identify and describe barriers and harder to generate creative solutions. Those who work on oral health issues seem very much “mired in the present” and are not thinking about bold new solutions. There were a number of things people interviewed for the study did *not* mention or request that seem like glaring omissions, such as foundation support to:

- Increase the supply of dentists
- Develop a new mid-level practitioner similar to a nurse practitioner or physician’s assistant
- Explore the use of expanded function dental auxiliaries
- Research and report on scope of practice and supervision requirements for dental hygienists and dental assistants
- Research state dental practice acts for restrictions they impose on medical providers delivering dental screening and fluoride treatments, and for the impact of the corporate practice of dentistry
- Improve advocacy efforts on behalf of water fluoridation
- Research and write about dental economics and how they differ from medical economics
- Educate governors or governors’ health staff on oral health
- Engage in leadership development among dental associations or dentists.

The three areas where RWJF investment would be most useful to breaking down policy barriers so states can move forward more forcefully to solve their access problems are:

### **Defining the Policy Problem**

There is much disagreement in states about the nature and dimensions of the oral health access problem. States that have not moved forward need consensus-building activities such as oral health policy academies, task forces and commissions in order to develop a unified vision of the

problem at hand. They also need help educating the media and working with the media to raise the visibility of oral health issues, and a broad public education effort aimed at the general public and high-risk groups such as immigrants, Medicaid and SCHIP recipients, low-income mothers and grandparents.

### **Developing Policy Solutions**

Assuming that a common definition of the problem has been accepted, states lack realistic and achievable policy solutions. There are also big holes in the picture; information is not shared for political reasons, not available or not given to people who could use it to make a difference. States need the sort of information that has been available in great quantities to spur the debate over health care reform: policy analyses, program evaluations, cost-benefit analyses, reports on best practices, and surveys to gather state-specific and local information. In particular, they need policy work that can explore alternative practice and service delivery models, new providers and any new ideas that would help open up the dialogue into new ways to solve problems in oral health. This work needs to be coupled with a broad dissemination effort to people in all areas of the policy process.

### **Build Political Support**

Oral health is a low priority for policymakers, most state health officials, advocacy groups and much of the general public. There are very few groups other than state dental and hygiene associations that work with the legislature on an oral health agenda, and they do not move forward together in any sustained fashion. Coalitions on oral health are either absent, missing members from key constituencies, weak, or poorly-funded and managed. Coalitions need training and tools to generate support for change in oral health policy. Even more serious, there is a dearth of consistent, strong leadership on oral health issues in legislatures and state agencies. There is a need for leadership development among legislators, education for legislative staff and support for state dental directors.

## I. Supply, Distribution and Practice Patterns of Dentists

### Barriers: Supply, Distribution and Practice Patterns of Dentists

#### *Too Few Dentists or Just Enough?*

One clear problem in states is the wide disparity of opinions about whether or not there is a **shortage of dentists** in their states. Most people, particularly those who work for state Medicaid agencies or health departments, safety net clinics or advocacy groups, feel that there is clearly a shortage of dentists in their state. Dental association officers and staff in the states we visited, on the other hand, generally say there is no shortage of dentists, although they are willing to admit there is a geographic maldistribution. State B's dental association president said "if there was valid scientific evidence of a shortage, we would support more students in existing dental schools, but no new schools." (The declining number of students admitted to dental school is further discussed in the "Dental Education" section.) In every state visited, people from all sides of the issue cited a **maldistribution of dentists**, with too few in rural, frontier, border and urban underserved areas to see patients regardless of income. State C has 25 counties without a dentist and State A has 3 counties with no dentists and 15 with fewer than five. About one-fifth of State E's counties do not have a dentist. It is particularly difficult to get specialty care in rural areas. There is also a tremendous problem attracting dentists to serve Native Americans on reservations.

According to states, any shortage that does exist is likely to be exacerbated in the coming years by the **aging of the dental workforce**. For example, 40% of State E's dentists will be retiring in the next ten years. This issue isn't uniformly understood by people within states as not every state collects this information and the dental associations, which receive the results of the annual American Dental Association surveys, don't generally release or share the information. State regulatory boards also may have the information but don't analyze or release it.

#### *Enough Dentists for Whom?*

Most people agree that there is a **shortage of those who are willing to treat low-income clients**, particularly those insured by Medicaid. Some dentists in State D resigned from the Blue Cross Blue Shield network rather than agree to take low-income patients paid for by a foundation's program. Part of the problem is that most dental practices are already full with patients who pay in cash or have private dental insurance so inadequate capacity exists to care for low-income patients. The president of one state dental association said "dentists don't feel like they need to see more patients" when asked if expanded function dental auxiliaries would be helpful to solve access problems. Another barrier is dentists' preconceived notions of what Medicaid patients are like. There is a **stigma** associated with this population and an assumption—often borne out—that there will be a high no-show rate. A number of people noted that dentists would rather donate care at a clinic than have "them" in their waiting rooms.

In every state, people said there are very few dentists who are **willing and able to treat children or adults with special health care needs**. Many dentists are taught in dental school to refer disabled patients and young children elsewhere, so they lack the training and comfort level to treat them. In State C, there is a three-week wait for oral health services for children with special health care needs. In State A, many families must drive long distances to the dental school so

they delay care until the need is critical because access is so difficult. In State D, a few disabled patients can receive care at a city hospital through the WICHE program (multi-state exchange program that provides slots in professional schools for state residents from states without schools). A fiscal analyst at the legislature said “it would take four years for them to serve the whole disabled population with one dental visit.”

### *Protecting a Cottage Industry*

Another set of barriers is the way dental practices are organized. Dentists by and large are in **solo practices**. A large percentage don't accept any insurance, let alone Medicaid, on philosophical or practical grounds, and ask patients with insurance to pay in full and seek reimbursement on their own. A dental educator in State B said, “in continuing education ‘management’ classes, dentists are taught not to accept insurance.” Many states have a **ban on the corporate practice of dentistry** in their dental practice act, which prevents dentists from working for any entity other than another dentist. This has been used to prevent the development of dental managed care and preserve the solo practice model. A state dental association president explained that in his view “the ban on corporate practice is because of quality of care. (Corporate practices) are mega-practices that operate faceless practices that aren't patient-oriented. (There is a lack of trust between dentist and patient so) patients don't know if care is really needed.” This provision also erects a legal barrier to the development of public health dental clinics or the addition of dental components to community health centers unless exceptions are written into law or regulations. State B experienced this problem and had to get an amendment in the law during the 1999 legislative session to allow them to hire rather than contract with dentists. One health center official said “dentists don't want to care for poor people but they don't want us to either.” State A also has a ban on the corporate practice of dentistry and allows exceptions only for unlicensed or foreign dentists, who can be employed by public health clinics or nonprofits to provide indigent care under the supervision of a licensed State A dentist.

### *Simmering Resentments Toward Dentists and Organized Dentistry*

One consistent finding was that there is a steady undercurrent of **negative feelings about dentists** among many of the people interviewed such as employers, purchasers of dental services, policy makers, state officials, community program directors, educators and regulators. This is important to describe so it can be factored into potential solutions. People in each state made some potentially offensive and controversial comments about typical personality types of dentists: they are difficult to work with, extremely independent, resistant to change, and don't partner well with other professionals. Some of the same personal characteristics that make dentists capable of performing high-risk tasks that require extreme precision with little or no room for error may be what makes them difficult. In State A, one state official said: “Dentists are perfectionists, anal retentive. They are very high maintenance. Dentists are never really happy.” In State D another state official said: “They're not willing to negotiate. I'm not as frustrated with them now, but I still think they could give a little bit more.”

**Few people understand the economics of dental practice** that give rise to many of these complaints. Some people express resentment that dentists behave more like business owners than health care providers and should have more concern about needy individuals and the health of the public. There are legislators and state officials who view dentists as uncooperative, greedy

and lacking in empathy. A State E official said, “Once a dentist has established a practice, they feel no obligation to the community.” While there were differences between comments about organized dentistry and individual dentists, there were negative feelings and experiences expressed about both by a broad range of people interviewed.

### *Not Enough Clinics*

In each state visited, people spoke of an **inadequate public health infrastructure** or safety net for dental care. The few community health centers that have dental clinics and the publicly or privately funded dental clinics are overwhelmed. According to the State C community health association, the pent-up demand is such that “whenever they open a dental site, the waiting list explodes” at *all* dental clinics in the state, after media report on low-cost dental services. However, State E’s Medicaid director also cautions that support for safety net dental services should not “let dentists off the hook” for providing care. He sees the safety net as a backup rather than a primary source of care. In State A, the dental director estimated that maybe 3% of the dental care in the state is provided with public funding through their 67 county health departments. The rest comes from private dentists. State E has only one community health center and it can’t keep up with demand for dental care. In the absence of sufficient public clinics, many people without insurance or a usual source of care go to the emergency room. A foundation-supported project in one part of State E found 800-900 emergency room visits each year for dental problems; 47% of those were for Medicaid-eligible patients.

Part of the problem is the extreme **difficulty in recruiting dentists to work in safety net settings**. The State C community health association says they currently have 15 openings for dentists at their clinics and two clinics staffed only by hygienists. Hygienists are not sufficient because “in community health centers, 20% is preventive and 80% is restorative. New patients are often a heavy investment in time and resources.” The dentists and hygienists who staff those clinics are personally and professionally challenged and need networking and support because of the high, unrelenting demands of the workload and the difficulties in caring for the population. Clinicians say that their patients have a high level of need and sometimes don’t follow up or complete their care, leading to a lot of frustration and worry among their caregivers.

### *Other Dental Providers*

In some states and in areas within states, there is a **shortage of hygienists, dental assistants and dental lab technicians**, although this comment cropped up less frequently than the similar comment about dentists. Since most dental hygienists don’t work full-time, it is harder to interpret the numbers on supply. In at least one state, a university official said, “organized hygienists are the same as dentists in not acknowledging there is a shortage.” Another factor that was not often discussed is that it’s difficult to get dental hygienists to volunteer. Most hygienists are women who balance work and family obligations.

In State C, a community health center official bemoans the fact that opportunities for screening are being missed and wants to reach out to non-dentists. She noted that “pediatricians see children up to 15 times before age 3” and could provide dental screening. Whereas, “in our state, we have only 65 pediatric dentists and even they don’t want to see children before 3 years.”

## **Opportunities for Intervention: Supply, Distribution and Practice Patterns of Dentists**

- To increase the number of providers willing to serve Medicaid patients, state and local officials all expressed a need for **help in expanding the safety net** for oral health services and recruiting full-time public health dentists.
- There is a need for **funding to purchase equipment** for offices or for outfitting mobile vans; one state suggested that matching funds be made available for this purpose. In State E, the Medicaid director wants funds to provide no-interest or low-interest loans to cover the capital costs of expansion for public health dental sites. State B community health centers need funds for capital expansions in underserved areas, but an even greater need is for funds to operate new clinics until they can become self-sustaining.
- There were also a few requests for **assistance in expanding school-based dental services** for children
- One person requested **placing a dental chair in a public hospital** if another setting is not available.
- It is clear that dentists prefer treating low-income patients in a setting other than their offices. For services outside the clinic or hospital setting, some communities, particularly in State D, want **help in coordinating volunteer dentists** to see low-income patients. There is also need for **dentists to supervise hygienists** (at whatever level is required by the state) who volunteer to provide screening and hygiene services in schools and other sites in low-income areas.
- In a comment related to dentists' attitudes, an administrator of the State C dental board said "a **class by Ms. Manners**" would be very useful for dentists.
- Only one person, an insurance company foundation executive, expressed the desire to have funds to investigate training of a **new type of mid-level dental provider**, similar to a nurse practitioner or a physician assistant.
- The State C community health association wants help developing a **program to train pediatricians to do screening for oral health problems** in the 0 to 3 population and work with dentists to solve them. Similarly, an official at the dental school at a public university in State B wants funds to provide **training for physicians, nurse practitioners and physician assistants in oral health** screenings and application of fluoride varnishes.
- An advocate in State A suggested that a "medical home" model similar to the one the American Academy of Pediatrics developed for children would be helpful to link children and families with a dentist or clinic and to **link together medical and dental care**.
- Two dental schools expressed a desire for **looser licensing requirements** to allow foreign-trained dentists to pass exams and establish a practice or teach.

## **II. Federal and State Policy and Programmatic Issues**

### **Barriers: Federal and State Policy and Programmatic Issues**

#### *Federal Policy Barriers*

A number of people, particularly state officials, pointed to obstacles to access created by the federal design of Medicaid and SCHIP. For example, the optional nature of adult dental services in Medicaid and children's dental services in SCHIP undercuts the importance of dental care and makes it among the first targets for Medicaid or SCHIP cutbacks. Also, since SCHIP is not an

entitlement, benefits can be capped. Low dollar caps (\$500 in State C and \$300 in State B) mean children with severe oral health needs don't have "meaningful" coverage and need to pay high out-of-pocket costs for care, seek a source of charity care or go without care over the cap. The federal law prohibiting enrolling children with health insurance in SCHIP has created access problems for children with health insurance but no dental coverage. State D expressed interest in creating a dental-only wrap-around plan for these kids if the law was changed to permit it. Also, many low-income people who need care but are unable to pay for it are not eligible for Medicaid. Safety net providers—already stretched treating Medicaid patients—treat these patients without reimbursement.

Another problem relating to federal law mentioned by several states is that the Federal Tort Claims Act—which protects most employees in community health centers from malpractice claims—does not extend to dentists. Some states have all but discarded certain options to increase the number of providers, such as employing volunteer or retired dentists in a clinic, because of the prohibitive cost of providing malpractice insurance for them.

#### *Reimbursement Rates*

Certain state policies adversely affect dentists' willingness to serve low-income populations (Medicaid, SCHIP, and uninsured). Dental associations in every state claimed that **reimbursement is too low**, although at least one dental association president noted that reimbursement has improved in the last several years, and States B and C raised reimbursement rates during the last legislative session. For the most part, the dental association message hits home with legislators and staff. A senator in State E remarked that "most procedures pay below cost." While this is true for the adult population, rates for children are actually in the 80-90<sup>th</sup> percentile—certainly not below cost—and Medicaid rates in some parts of the state are above private-pay rates. The State C dental association went so far as to say that inadequate rates result in "MASH dentistry" and a "double standard of care" with some profiteering dentists setting up Medicaid-only clinics and performing "factory dentistry." The representative went on to add that the "crisis in access would go away if dentists were paid at the 75<sup>th</sup> percentile." Some people suggested that the methods states use to calculate reimbursement are outdated and inadequate. (To this end, the Milbank Memorial Fund has developed an alternative reimbursement model using interactive actuarial software.)

Barriers to access also result when **some procedures or services receive no reimbursement**. For example, coordination between physicians and dentists is rarely funded, though some see the need for it. State C's SCHIP director believes that "whenever kids interact with the health care system, primary care providers should refer and link them to needed oral health services. Any case management or follow-up should include oral health." However, this type of coordination is rarely funded. Also, states rarely provide extra reimbursement for the elderly or people with disabilities, as State E does, though it is more difficult and time-consuming to treat these patients than to treat children.

#### *Administrative Barriers and Patient Compliance*

Other factors that make dentists unwilling to serve low-income patients are continuing **administrative hassles**, although some states have instituted electronic billing, begun using ADA billing codes and claim forms, and reduced or eliminated prior authorization requirements.

State E's dental association remarked that the time required to receive payment has doubled to 6-9 weeks in 2002 for an unknown reason. **Failure to keep appointments** is another factor that limits dentists' willingness to serve low-income patients. State officials agree with dentists that no-shows are problematic but have made little headway in addressing the problem. There are long waiting lists in both public and private care settings.

#### *Limited Public Employee Benefits*

Many feel that oral health is systematically undervalued. The low valuation of dental care is also reflected in the **uneven benefit packages for state employees**: dental benefits are not subsidized for State E's employees and dependents or most State A workers. If benefits are offered, the reimbursement levels are often low. Roughly 60% of full-time public employees have dental insurance, but the services covered, copayments, deductibles and dollar caps vary.

#### *Fluoridation*

Although each state we visited has some funds for them, **programs to fluoridate water systems are generally small and on the defensive**. During the last legislative session, State B cut its fluoridation budget by 80% to help offset a small part of the cost of the Medicaid reimbursement rate increase. The state dental director said the current state health commissioner does not believe fluoride is beneficial and has fears about its safety. Also in State B, one of the largest cities in the country without fluoride voted a few years ago to fluoridate after years of contentious debate and an enormous community coalition effort but has yet to implement it. In State D, legislative leaders had been working at the local and state levels to get communities funds to fluoridate water, but county boards voted it down for several years. A grassroots effort in State D won a referendum approving fluoridation in three cities last year, although implementing it has been stalled by court challenges and efforts among some smaller communities to opt out of the water system.

#### *Scope of Practice and Supervision Battles*

Persistent opposition by state dental associations to the attempts by dental hygienists to expand their **scope of practice and loosen supervision requirements** was mentioned in every state we visited. One community health center official said: "Dentists are the most territorial mammals on the face of the earth, except maybe dogs." This struggle is similar to others between professionals, such as physicians and nursing groups. These are very difficult issues for legislatures because they pit important groups against each other, involve complex technical issues unique to each profession and have the potential to hurt or help the public. Hygienists are trained to provide various preventive and "triage" services but are often prevented from doing so under state practice acts. Hygienists feel they can remedy access problems by going directly to underserved populations (thus removing transportation and outreach barriers and solving the no-show problem). In their own defense, dental associations disagree that changes in scope of practice or supervision are needed to improve access, arguing that most low-income patients need restorative care which can only be performed by a dentist.

In the states we visited, organized dentistry has consistently opposed hygienists' attempts to practice to the full extent of their training under any level of supervision and opposed attempts to perform services off-site that they can do under a dentist's supervision. There seem to be **big disparities in practice acts governing hygienists and assistants** between and within states. In

State A, hygienists need direct supervision to apply sealants, while in other states, sealants can be applied by dental assistants. In State E, hygienists can perform a full range of services on reservations, but not in private dental offices a few miles away. In State C, hygienists can get their own Medicaid provider numbers and set up independent practices. However, the dental practice act in State C will be reauthorized next year and most people expect that independent practice and the ability to get separate Medicaid provider numbers will be challenged by the dental association.

There were several comments from hygienists, advocates and educators about the suspected presence of sexism and a “good ol’ boys network,” in keeping dental hygienists from expanding their scope of practice or practicing more independently, since the great majority of dentists are men and hygienists are mostly women. A dental educator in State B said the newly enacted program that will allow dentists to provide clinical training to prospective hygienists is “a slap in the face of the hygiene profession and to women.” There are also differences in practice between dentists and hygienists that deteriorate their working relationship and reduce mutual respect. For example, dentists believe in applying sealants only to healthy teeth, while hygienists in two states said they have been taught that sealing a decayed tooth prevents further decay and still allows a dentist to restore it.

#### *State Fiscal Woes*

All of these factors are overlaid by the fact that **states are facing budget crises**. New state-only initiatives regarding dental health—which many policymakers fail to recognize as an important health concern—are unlikely to be funded. The goal of most state officials is simply preservation of programs, rather than expansion. (In fact, since the beginning of this project eight states have cut back on or eliminated adult dental benefits in Medicaid and four more considered doing so.) Hiring freezes in at least two states we visited (States A and E) mean that open oral health positions cannot be filled. In the case of State E, the hiring freeze has blocked state agency officials from hiring a needed data analyst to complete an evaluation of a case management program, despite CDC funding for the position. (They will attempt to contract with someone for the life of the CDC grant to circumvent the freeze.)

#### **Opportunities for Intervention: Federal and State Policy Issues**

- A number of states said they needed **funds to make existing programs, such as Medicaid or SCHIP, work better**. State funds to maintain oral health program staff are insufficient. State agencies said they needed funds to **increase reimbursement rates** under Medicaid and SCHIP because revenues are too scarce and, in some cases, rates are so low that increases to a realistic level are simply unaffordable. Another state suggested that funds to provide **incentives for dentists who treat disabled** and low-income, high-need patients would be helpful. State A’s dental association wants a small grant to conduct **outreach to dentists** to become Medicaid providers. An advocate for special needs kids in State A wants the state to establish a **referral hotline** that would provide information about which dentists are accepting new Medicaid patients.
- **Fluoridation** was a topic on many wish lists. Several states said they needed funds to expand fluoridation, specifically to buy equipment for communities to use to fluoridate their water supplies.

- There were a few ideas and requests for **assistance to change the current financing or delivery system** or experiment with new practice models. The State B dental director wants help establishing a non-entitlement dental care program for adults. Another state wanted seed money to establish or support “model practices” and demonstration programs to improve access. One state requested support for development of a dental HMO that uses evidence-based practices, focuses on prevention and evaluates outcomes.
- Finally, across the board, dental hygienists requested help in working to **loosen supervision and expand scope of practice** to the extent of their training so they can help improve access to care for low-income people.

### III. Dental Education

#### Barriers: Dental Education

Other than Public Health Service Act provisions and the National Health Service Corps, which both offer limited support for dental professionals, there is **little federal support for dental education**. Federal support ended in the late 1970s in response to concerns about a potential glut of dentists and some reported difficulties by new dentists seeking to establish a practice. Other than general support for public universities with dental schools, **state support is limited** to loan repayment or scholarship plans. Though such programs exist in statute, they may be poorly funded by states and limited in number. For example, there are only five slots in State B. The State E legislature specified population ranges for each of the three loan repayment slots created in 2000; only the slot in the most populous area has been filled.

Eighteen states (soon to be 16 with new schools in two states) have no dental school. States that solve that dilemma through cooperative arrangements such as WICHE have increased opportunities for their students to receive a dental education, but have no guarantees that they will return to their home state. A **shrinking number of dental school applicants** are competing for a shrinking number of dental school slots. Even if a school acknowledges a shortage of dentists and wish to increase the number of graduates, expansions in class size are limited by a **shortage of dental school professors**. Dental schools have trouble recruiting faculty because salaries are much lower than a dentist can make in private practice. Furthermore, some people, such as the dean of a dental school in State C, believe the **lack of diversity in the dental profession** is detrimental to care of the underserved. According to a state official in State E, young dentists view their profession “as a business, not healthcare.” Other people raised questions about the lessons students learn in dental school; one state official heard anecdotally from students that their dental school blatantly advised them not to treat Medicaid patients.

#### Opportunities for Intervention: Dental Education

*In states with a dental school. . .*

- Non-profit providers need funds to **hire dentists to provide supervision** for dental graduates and dental students who are doing residencies and externships in sites that provide care to underserved patients.
- A related request was for **changing dental education** so that rotations through community clinics are a condition of graduation.

- Several state officials also wanted funds to **promote the dental profession** to high schools students, recruit dentists to the state (particularly to rural and underserved locations) and recruit “a different type of student” into dentistry (particularly nontraditional students, minorities, women and people interested in public service).

*In states without a dental school. . .*

- States without a dental school have different needs than states with dental schools. For example, State E needs **funds to provide placements** for second and third year dental students. (They don’t have the clinic infrastructure to house visiting dental students or the funds to pay someone to supervise them.)
- States without a dental school need help **developing a satellite school** with a neighboring state’s dental school.
- These states also want help in **designing incentives to ensure that state residents return** to the state after attending dental school elsewhere.

#### IV. Research Issues

##### **Barriers: Research Issues**

In every state, people expressed the need for more information to help them do their jobs or move the policy process forward. There were two general types of requests: one for more **data on the nature and extent of current access problems** and the second for **research, evaluation or policy analyses** on financing or program models to fix access problems. State A’s Medicaid director said they “need information to support state efforts to invest in dental services. It is very difficult to generate support for dental services in this state.” One legislative staffer said he needed much more information about the exact nature of the access problem, asking, “how much is due to factors specific to low-income people and how much is due to the Medicaid system?”

A number of states want more current and detailed information about the **prevalence of oral health problems and unmet need** among different populations, not only to spur policy and program development but to develop realistic cost projections of new dental benefits in Medicaid and SCHIP. State A is piecing together small amounts of money from several sources to do a surveillance project on Head Start students, 3<sup>rd</sup> and 9<sup>th</sup> graders. The State C SCHIP director wants to know what true need is for dental services among children in the SCHIP program (between 133% and 185% of the FPL) once previous pent-up demand has been satisfied so accurate cost projections can be made. The State B dental director wants to collect and analyze data on what happens to children who need more care than the SCHIP benefits provide (over the \$300 therapeutic cap), partly to spur changes in benefit design and partly to better assess the true costs of a comprehensive benefit.

A few states have studied, or wish to study, **how much Medicaid spends on emergency care** for dental pain and avoidable oral health problems that could be treated by a dentist. A related question was posed about the cost of hospital dental care for disabled patients for care that could be delivered in a dental office if qualified dentists were available. Another fact not available for states or localities is the number of school days missed by children due to oral health problems; this is seen to be key to spurring investment in oral health programs for children. A disability

advocate in State B wants information about the impact of untreated dental problems and poor oral health on employability.

The questions on financing and program design either involve how to make the current system work better or ways to experiment with different models. A nagging question involves the need for research documenting the **impact of raising reimbursement rates**. According to the State A Medicaid staff, “legislative staff in State A believe that reimbursement rate increases are a waste of money because they don’t increase dentists’ participation.” The State C Medicaid agency wants a detailed study to compare Medicaid and SCHIP oral health programs across states with respect to codes, reimbursement rates and administrative processes to help them better manage the program. Their second question involves how much of the capitated rate for dental should be spent on education of clients and their families about good oral health practices.

One person said, “new thinking is needed about **how to get dentists to see low-income patients**. Should it be a daily rate to see patients one day a week or one day a month?” Another asked, “what works to reach the low-income population who mostly don’t get information through reading?” State E was in the midst of evaluating a case management program when the program director left her job and the project was left uncompleted. State A Medicaid would also like to test a prepaid dental plan for Medicaid beneficiaries on a voluntary basis in one county.

### **Opportunities for Intervention: Research Issues**

- In every state, someone asked for **state-specific data about unmet oral health needs** in specific populations, including surveillance data for children at specific grade levels.
- Advocates, legislators and legislative staff need **policy analyses** to review data in the context of specific interventions and explore the costs and benefits of each.
- Many states want funds for **demonstration or pilot projects** to help states show what works to fix system problems and funds to produce **objective evaluations** to document lessons learned.
- Descriptions of best practices and **dissemination of information about successful programs** are lacking and very much needed, as well as funds to replicate successful programs once they are identified.
- **Sharing information** that now exists—such as program evaluations of state programs or national data sets—is important but is not being done. Information to move policy forward has not been made available or is not known to most people working on these issues at the state level.

## **V. Leadership**

### **Barriers: Leadership**

A problem consistently mentioned across states is the **low level of education, awareness and interest among legislators** about oral health issues. Advocacy groups expressed a need to have legislative champions in each chamber of their legislature. In the states visited, State B is losing both of its champions this year to redistricting, State D is losing one of its two champions to retirement, and State A has no champions on health issues at all, let alone on dental. At least one

legislator in State E considers herself a champion of dental health, but with a legislature that meets for only 80 days every two years, she finds it difficult to devote too much energy to one of many pressing issues. In State C, a legislative leader pushed to allow independent practice dental hygienists to bill Medicaid; that leader is now the governor, thwarting the hopes of the dental association to repeal that law. However, there doesn't appear to be a current legislative champion in State C. While advocates see legislative awareness and leadership as crucial, not all legislators agree they need much education. One legislator suggested that broad education efforts shouldn't be more elaborate than bullet-point notes on a single page. Since State E's legislative session is so short, her colleagues rely heavily on the relevant committee's assessment of a bill; therefore, she doesn't think broad education efforts in the legislature need "glossy paper" presentations.

**Education about the differences in the economics of dental versus medical practices** is clearly needed to lend a rational underpinning to debates about raising Medicaid and SCHIP reimbursement rates. In the absence of more education on these issues, there are common misperceptions among legislators that give rise to sentiments such as "dentists are rich people who don't need more money in reimbursement rates." One State D senator allegedly asked at a hearing: "Did you know dentists make more than physicians?" Education about the importance of oral health, the need among specific populations, and gaps in services are also important.

Another related issue is the need for **educating legislative staff** about oral health issues. They are the "detail" people who work on bill drafting, cost estimates, program analysis, committee hearings, and executive branch oversight. Staff are particularly important in the 11 states where term limits have taken effect (there are 6 more where they have been enacted but not implemented yet), and other states with high political turnover because they supply the institutional memory lacking in the new crop of legislators. The level of awareness and knowledge in the legislative staff interviewed for this project was spotty.

In addition to leadership in the legislature, a number of people said it is important to have a **full-time dental director** in each state department to provide leadership on oral health issues. In California, Maryland, Nevada, Rhode Island, West Virginia and Wyoming, there is a part-time dental director. In 41 states there is a full-time dental director. Currently, Washington, Oregon and Michigan have vacant dental director positions. The dental director is generally the advocate within state government, sometimes in conjunction with a dental analyst or director within the Medicaid agency, for funding for oral health programs. They make budget requests and other recommendations to health commissioners and Medicaid directors, who in turn make recommendations to health and human service secretaries and to governors.

Many public officials and dental professionals remarked that consumers and policymakers do not understand that oral health is a part of overall health. As a result, **oral health seems to be a low priority for some state health agency officials**. Without consistent strong leadership within health departments and Medicaid agencies it is difficult to get support for oral health programs. Dental directors in States A, B, and D said they did not get support from the health commissioner or governor in asking the legislature for funding for health programs. Strong leadership may have a cost, however. The State B dental director told us that his two predecessors had been fired for being too "activist" and that he had not been consulted by the Department of Human

Services (which runs Medicaid and SCHIP) about the planning or implementation of the dental benefit. Since oral health is a small percentage of overall spending in Medicaid and public health, it doesn't garner much attention in the policymaking or budgeting processes.

### **Opportunities for Intervention: Leadership**

- Throughout the visits, people spoke of the need to **develop leaders among legislators**. In each state, people said they needed **education for legislators and legislative staff** to elevate the issue of access to oral health care on the priority list and convince them of the need for investment in oral health programs. There was a particular sense of urgency for this task in states that were losing their leaders to redistricting or retirement. Special attention should be given to members and chairs of health committees since these legislators may have more power to move the debate and influence other members on health issues.
- Some states want **funds to hire oral health staff** due to state budget shortfalls and hiring freezes.

## **VI. Advocacy**

### **Barriers: Advocacy**

#### *Lack of A Powerful Voice*

A consistent theme in states is the **lack of effective advocacy** for oral health issues in general, and access to dental care for low-income people in particular. The State D legislative staff director for the appropriations committee said “there is no constituency for it. Because of the limited time legislators have during a session to consider specific populations or services, the burden to push an issue is on the advocacy groups.”

State E expressed the need for a coalition or a “powerful voice” to speak out on behalf of oral health. State D, while it has a coalition, says “we are flying by the seat of our pants here,” and they lack knowledge about how to operate it and funds to staff it. In State E, the maternal and child health director said the state lacks “funds for coalition-building.” The State A health commissioner claims “the state needs funds for a staff person to support the coalition.” State A has a coalition that grew out of its work with the NGA policy academy, but it lacks broad representation and political clout. State B has no oral health coalition. The maternal and child health coalition in State B does not lobby on oral health although it did work to get dental benefits included in SCHIP. The director of the coalition said, “oral health needs to get on the list of needs and become a priority.” State C also lacks a coalition, although advocates did organize for a one-time push to add dental coverage to SCHIP.

**Advocacy groups clearly need more and better information** to be successful. An advocate in State A said, “there is no objective material available that we can use for advocacy on dental and we have no time to develop it.” In States A and D, advocates pointed to campaigns on issues that were coordinated by a national office that could supply materials and data to state groups that can be tailored to their needs. They said there is nothing like it for dental access. A reporter for a local newspaper in State A pointed out that the advocacy groups that lobby for services for

children and the elderly are different, and that “between older people and kids, kids rarely win. Children’s issues are a low priority compared to senior citizens.”

Oral health is also not a priority for advocacy groups in the disability or special needs kids communities. In States A and B, the **disability community says that oral health is a “back burner issue”** because access to health care can be a life or death issue.

#### *Dental Associations are Not the Best Advocates for Low-Income Programs*

In all the states we visited, the only or most visible group lobbying the state legislature is the state dental association. **Organized dentistry is extremely powerful** at the state level, second in influence perhaps only to physicians, and is seen as the main group that determines policy outcomes on oral health programs. In State A, a senior legislative staffer stated, without any awareness that her statement was controversial, that “my chairman won’t support anything the dental association opposes.” **Dental associations are poor advocates for access to dental services for Medicaid and SCHIP** beneficiaries because they are perceived as self-serving in seeking increased reimbursement rates. They are sometimes perceived as providing false leadership or “lip service” to access issues for low-income people.

#### *Hygienists are Relatively Politically Inactive*

On the contrary, according to the state officials we visited, **dental hygiene associations are not powerful**. Hygienists are less likely than dentists to belong to and be active in their state associations. This lessens the funding available for lobbying on their issues and lessens their clout. Their solutions to problems are not brought before the legislature as often, considered as carefully, and given the same weight as those brought by the dentists. Besides dental associations and dental hygienist associations, community health centers were mentioned as meeting with legislatures occasionally on oral health issues, primarily to request funding for services.

#### *Decisions are Made Out of the Public Eye*

An important issue related to advocacy is that many decisions affecting oral health programs are made in isolation; there seems to be **no consensus-building function** within the states we visited. Information about the problem at hand (potential budget cuts, workforce shortages, etc.) is not shared, and decisions about how to solve them are made with no broad discussion involving different sectors of the policy community. For example, State D recently cut its dental benefits in SCHIP because of state budget shortfalls. Although there were unspent federal SCHIP funds, the state did not have the funds needed to match them. The decision to cut dental benefits, rather than cut other benefits or reduce costs in some other way, was made by the SCHIP director without consulting the legislature, dental association or advocacy groups. Similarly, legislative leaders made the decision to cut adult dental benefits in Medicaid in State D without consulting the health committee, the health department or advocacy groups.

The relative weakness of advocacy groups allows these important decisions to be kept out of the public eye. They seem ineffective at “spreading the word” to their members and the general public about a pending decision so they can attempt to influence it.

## **Opportunities for Intervention: Advocacy**

- Advocates universally claimed they needed **information and objective data on oral health** problems in their state and an evaluation of policies tried by other states. Other people echoed the need for assistance in **translating data** and information into a form that motivates people to act.
- Advocacy groups also said they need **financial support**.
- Another theme was the need for support to **develop coalitions, staff them and help them be effective** in reaching their goals. A closer working relationship between the legislature, executive branch agencies, program level administrators, providers and advocacy groups can ensure an exchange of information and a discussion about the potential impact of a pending policy change, even if consensus is not possible.

## **VII. Public Education**

### **Barriers: Public Education**

The need for **educating the public** about the importance of oral health and its relationship to overall health was mentioned frequently by a wide variety of people. An advocate in State B said “lack of access to oral health services is not considered a health care crisis.” Low-income people and immigrants in particular were singled out as in need of education because they don’t practice preventive measures sufficiently and only seem to come in for care when they experience pain. Some low-income immigrants and certain cultural groups also feel that losing teeth is a normal part of aging. A legislative staffer to the appropriations committee in State D said, “lack of demand for oral health services is a barrier. If more people wanted the services, they would be willing to pay more taxes to make sure they get them.” Older people with dentures don’t realize they still need care and screening for oral cancer. The lack of education and awareness about what constitutes quality oral health care is pervasive.

Compounding this issue is a host of barriers to **enlisting the media** in the effort to educate the public. Electronic media rarely cover issues in oral health policy because they are too long and complicated to explain in the short segments reserved for news stories and aren’t considered interesting enough for longer features. Print media reporters said that health policy issues in general are considered by editors to bore readers. Reporters interviewed said they can only write about health policy issues if they get a local angle to the story, such as a local clinic adding or losing a dental component, or if they can cover them as part of a story about state or local government. Occasionally, reports issued by national groups can be covered if they shed light on the state’s performance on an issue or problem. A reporter in State D said he needs help finding “success stories and personal examples” in order to provide a local hook and make the story newsworthy or appropriate for a feature story. A State A reporter said “I need more national reports with state-by-state data so I can run state-specific articles; local information would also be helpful.” With regards to educating the public about the importance of oral health care and the number of low-income people who can’t get care, one reporter said, “unmet need is not newsworthy.”

## **Opportunities for Intervention: Public Education**

- People from all sides of this issue requested financial and operational support to **educate the general public** about the importance of oral health, particularly about disease prevention, fluoridation and the links between poor oral health and low birthweight babies, pre-term births, and cardiovascular disease. One coalition executive called for “a big public relations and awareness campaign similar to *Watch Your Mouth* targeted to legislators and the public.”
- The State A disability community suggested that families needed education about what constitutes **quality oral health care**.
- Other suggestions or requests were to **educate specific patient groups** seen as key to improving access to oral health care or patient behavior. A foundation in State C feels that the group most important to educate are **parents and grandparents** of low-income children. State E requested help in providing oral health information to **low-income mothers** through their home-visiting program. State officials also called for support to educate **the Medicaid population** about how and when to seek care and how to prevent oral health problems.
- Finally, there were a number of requests to support **education for health care reporters**, primarily print media. Both reporters interviewed said they needed help building their knowledge base about oral health and the programs that are used to solve problems. Invitations to conferences on health policy issues were suggested as a good method to provide education. Reporters can’t accept gifts, but waiving registration fees for conferences was one suggestion as a way to promote attendance.

## **VIII. What Didn’t Surface on Wish Lists**

### *Long on Barriers, Short on Solutions*

One of the interesting things about the many interviews conducted as part of this study is the lack of a one-to-one relationship between barriers identified and requests for assistance or ideas for foundation investment. Frequently, people identified barriers but requested assistance to do something other than address those barriers. This may be because it is always easier to identify problems than to solve them. Also, some people interviewed had no idea how foundations work in terms of funding constraints or grantmaking goals; they had few or inappropriate ideas about how foundation support might help (for example, suggesting foundation funds could be used to pay for services or increased reimbursement rates). Other interviewees were simply giving “wish lists” without regard to a foundation’s potential role or the financial or political barriers in achieving the change. However, it is very clear that **most people are very rooted in the present**. They acknowledge the power of the state and national dental associations and the current structure of dental care financing and service delivery in this country and have trouble looking beyond these institutions.

### *Some Important Omissions*

Given the fact that people assume the status quo will prevail, it is not surprising that almost no one suggested foundation support to increase the supply of dentists even though many people feel there is a shortage in their states. Also, only one person suggested trying to develop a new mid-level practitioner such as nurse practitioner or physician’s assistant which could extend the capacity of the existing dental workforce and help improve access in rural areas. This may be

because of the difficulty dental hygienists have in expanding their scope of practice and loosening supervision; if an established profession has made no inroads, how could another a new type of professional hope to deliver any of the services dentists now provide? It was interesting that no one suggested researching and writing a report about or working to reduce the wide variations in scope of practice and supervision requirements for dental hygienists and dental assistants. For that matter, although the ban on the corporate practice of dentistry was mentioned as a barrier in several states, no one suggested doing a study on how many states have such a ban, what the impact has been and how states have fared without it. Another request notable by its absence is support for advocacy efforts surrounding water fluoridation. Many people asked for funds to provide equipment for fluoridation, but none for information or advocacy, although it could help make difference in these local decisions. No one requested a paper or other education effort explaining the differences between dental and medical practice, or “dental economics,” to policymakers but it is clearly needed. Most people don’t know or appreciate why dentists refuse to see patients for whom reimbursements are below cost. No one suggested education on oral health for governors or their health policy staffs to increase their support and involvement. Finally, no one suggested leadership development among dentists or dental associations even though many leaders on low-income access issues in states come from that community.

## **IX. Conclusion**

### *Three Components for Policy Change*

A well-known book, John Kingdon’s Agendas, Alternatives and Public Policy, puts forward a simple framework for analyzing the components needed for policy change. He says that three things have to be present in order to move an issue forward. First, there must be a commonly accepted definition of the problem. Second, there must be a workable policy solution to the problem as it is defined. Third, there must be political support for the solution among all the relevant parties required to enact it. These three things must occur together in proportion to one another for policy change to take place. A huge problem coupled with a small solution without political support from all important actors will not work. A well-defined problem with an unpalatable solution will not get the political support to work. There are many examples of this framework from the site visits that explain why the states visited have not moved forward forcefully to solve problems and point to interventions that might break the logjams.

### *Defining the Problem*

In the states NCSL visited, there was not a commonly accepted definition of the problem causing access difficulties. In particular, there is strong disagreement about whether there is a shortage of dentists or just a maldistribution and too few who are willing to see publicly insured patients and people with disabilities. There is also disagreement about how to define problems of access within Medicaid. Is it a problem of poor oral hygiene, cultural beliefs and compliance among patients? Do patients not want dental care? Is it a problem of low participation in Medicaid among dentists due to reimbursement rates and administrative hassles? Or are dental practices already at capacity and therefore acting as any business should to optimize profits by not substituting low paying patients for those who pay cash in full? Assuming that access problems are multi-dimensional and complex, there is little consensus among people working from different perspectives in states about which specific policies need to be changed—let alone what

those changes should look like. The process of defining the problem is not simply one of obtaining information to answer a question, but of perception and momentum behind an issue generated by people working on it from all sectors.

Data that might be used to arrive at a common definition of the problem is either not available at all, not shared for political reasons or not understood by people who are in a position to make decisions. State agencies that might have useful data don't have the funds or staff to retrieve it or have not been asked for it. Dental associations view some data and information as proprietary and potentially harmful to their interests. In State B, the dental association is willing to support some new slots "if valid scientific evidence showed a shortage" but this evidence is unlikely to be available to a state agency, the legislature, or advocacy groups without dental association cooperation in obtaining it. One state dental director said he would have to file a Freedom of Information Request in his own state to get SCHIP utilization data, although he has Medicaid data and both programs are in his department. In State A, the state board of dental examiners claimed they didn't have personnel with the time or skill to retrieve information on the age of the dental care workforce from individual dental licenses, but they said the dental association had the information. The dental association said they don't have it but the health department does. The health department says they don't have it either. Therefore, the governor and legislature do not know that a large percentage of the dental workforce may retire in the next decade, without sufficient numbers of new dentists being trained to replace them.

The media—who often generate interest in an issue, broaden awareness of a problem and help shape the definition of the problem in its coverage—are largely silent on access to oral health care. For the most part, the public isn't hearing about these issues on television, radio or in newspapers and pressing policy makers for action. Television covers shorter stories and local print media rarely cover health policy issues, particularly issues without a local angle. Political leaders aren't convening hearings or public forums to discuss access to oral health care because these problems aren't "on the radar screen."

In order to move the policy process forward, RWJF support could:

- Fund **consensus-building** activities in states such as oral health policy academies, task forces and commissions and provide ongoing technical assistance to ensure lasting results.
- Be used to **educate the media** and work with editorial boards on oral health issues.
- Help **educate both the general public and high-risk groups** such as immigrants, Medicaid and SCHIP recipients and low-income mothers and grandparents about prevention, the importance of oral health to overall well-being, and how to use services.

### *Formulating a Policy Solution*

In the states we visited, there was no agreement about workable policy solutions, putting aside the lack of consensus about how to define the problem. For example, if a state has decided that its access problems are due to workforce shortages, there are a variety of potential policy solutions. One obvious solution might be to expand the number of dentists being trained in the state's dental schools, or, for states without a dental school, to buy slots in a neighboring state's school or establish a residency program to bring third-year students or graduates to the state. With the exception of State E's dental association, every state dental association we visited had already opposed that solution in recent years, saying the state had an adequate number of dentists

and an increased supply would threaten the practices of currently licensed dentists. And, in an exercise of dental association power, a satellite residency program in State B that was passed and funded by the legislature over dentist opposition died in implementation. As a professor at the dental school said “we attempted to establish dental residences but the local dental societies ran us off.”

Even if there is general agreement about expanding the workforce through dental education, a host of additional problems arise. How should the state address: a shrinking number of applicants for dental schools? Lack of diversity and a public service orientation among prospective dental students? Reduced state funding available for dental schools? The dental faculty shortage? A shortage of classrooms and dental chairs for teaching? In State E, there aren't enough state funds to establish residency slots for third-year dental students, although most people agree there is a shortage of dentists. In State C, the dental school feels that dentists' income of more than \$160,000 a year attracts a certain kind of student (one who is interested in high earnings) and leads to dental faculty shortages. Nationwide, there are more than 300 dental faculty vacancies, 70% in clinical training.

Another potential solution for the problem of workforce shortages is enlisting other providers to deliver services. Dental hygienists have been working consistently in states to expand their scope of practice and loosen supervision requirements but have met with opposition from the dental association, which argues that hygienists' training cannot address the restorative care needs of low-income patients. Of the states visited, only in State C can hygienists practice independently and bill Medicaid directly. In State A, which has very tight supervision requirements, a state oral health council was asked to consider independent practice for hygienists and they said “over my dead body because...dental practices will go bankrupt.” Objective analysts might look at the situation and see that dentists and hygienists each have training to improve access in two different but equally important ways, through restorative care and prevention, respectively. However, crafting a policy that reflects this has proven to be too tough to do in almost all states.

Another potential new source of care is pediatricians, pediatric nurse practitioners and other medical personnel who can be taught to screen for dental caries, apply topical fluoride, educate patients and parents about proper oral hygiene and make referrals to dentists for restorative care. In most states, dental practice acts define some of these services as the illegal practice of dentistry if performed by anyone other than a dentist licensed to practice in that state, punishable by fines and revocations of license. Potential changes in the dental practice act are fraught with heated discussions about endangering the quality of care for patients. The dean of a dental school in State C has begun training ear, nose, and throat clinicians in the basics of oral health and wants to expand to other medical professionals, and in State B, a hygiene professor—quietly, to avoid being blocked by the dental association—is considering a similar effort

Each of these potential methods for expanding the workforce has been attempted in a site visit state. However, because of the dearth of data collection and evaluation resources, the innovative state and others considering modeling the policy are left with two unanswerable questions: Did the policy work?, and Why or why not? Consequently, though facing similar problems and

considering similar solutions, each state is needlessly working in a policy vacuum. In order to move the policy process forward, RWJF support could:

- Fund policy analyses, program evaluations, cost-benefit analyses, reports of best practices and surveys to gather policy relevant state and local data;
- Fund some policy work that would explore alternative practice and service delivery models, new providers, and “out of the box” thinking;
- Support a dissemination effort targeted at people in every part of the policy process if needed.

### *The Politics*

Finally, in the states we visited, there was not broad political support for policy change in oral health. There are few groups working on oral health issues, and they do not speak with one voice. State dental associations are among the two or three most powerful groups in state politics and are generally the only people speaking with legislators and staff about oral health issues. There were overt statements made by people interviewed about their strong influence in state policy matters; in most states at most times, dental associations can stop any initiative they oppose. Organized dentistry is not seen as effective in lobbying for increased reimbursement rates because they appear self-serving rather than interested in access for low-income people. However, in the states we visited, dental associations had not been active in seeking many other remedies for access problems. Hygienists aren't terribly active politically and have a difficult time pursuing their agenda with state legislatures to the extent that it conflicts with the dentists. Community health centers lobby but for many health issues, not just dental care.

Most state-based health advocacy groups are not active on oral health issues, and if they work on it at all, it's a low priority. The natural allies among advocacy groups are maternal and child health, disability, and poverty and welfare groups, but none work on oral health in any sustained fashion. Also, the leaders among state executive branch agencies do not place oral health high on the priority list. Health commissioners and Medicaid directors have many important issues on their plates, and dental directors do not generally have the clout to raise the profile of their issues any higher. This reflects the generally lower priority that the public places on oral health compared to physical health.

Finally, there are few champions for oral health in legislatures. Most legislators are not educated about these issues and many states don't have any that are committed and willing to push policy initiatives forward. Some states with knowledgeable committed legislators are losing them to redistricting or term limits with no one to fill the void. Legislative staffs also need education. Health and appropriations committees cover a broad range of issues during hearings and access to Medicaid or oral health may receive only a few minutes. In states with a history of low taxes and an emphasis on personal responsibility rather than government assistance, it can take extraordinary intervention, such as a lawsuit filed against the state, to spur policy action.

In order to move the policy process forward, RWJF support could:

- Be extremely useful in supporting coalition building and advocacy efforts, both outside of government and including government;
- Assist in educating legislators and legislative staff, and developing legislative leadership on oral health issues.



## **Appendices**

- I. Methodology**
- II. State A Site Visit Report**
- III. State B Site Visit Report**
- IV. State C Site Visit Report**
- V. State D Site Visit Report**
- VI. State E Site Visit Report**
- VII. Summary and Participant Lists of April 11 Meeting of National Policy Experts and April 12 State Focus Group**

## **Appendix 1**

### **Methodology**

There were three sets of activities involved in this study: data gathering and analysis; conducting a meeting of national experts and a focus group of state officials and advocates; site visits to five states.

NCSL gathered and analyzed a wide variety of reports, peer reviewed articles and other information about state dental programs in Medicaid and SCHIP, and oral health improvement efforts in general. Prior to the beginning of this contract, NCSL filed a Freedom of Information Request with the Centers for Medicare and Medicaid Services to obtain copies of reports filed with CMS by states about access to dental services for children. NCSL also collected dozens of reports produced in the last five years by state departments, commissions, coalitions and task forces about oral health. These included materials submitted to NGA by states applying for the oral health policy academies. NCSL prepared summary sheets with two pages of data about each state program. The goal was to collect in one place basic information about dental education, hygiene education, the dental and hygiene workforce, children's services in Medicaid, reimbursement rates and administrative simplifications in Medicaid, regulatory issues and state program leadership and interventions.

In order to select states for site visits, NCSL reviewed state documents, collected data and compiled two page summary sheets on each state. The goal was to identify states that are not considered the front runners in oral health programming, nor are they considered the least active and promising as sites for investment of RWJF resources. The five states with the highest reimbursement rates and three more that are considered "best practices" states with respect to the priority placed on oral health and the development of their programming were eliminated from consideration. NCSL then identified 11 states that fit the "middle" criteria and presented details on seven that represented a range of states geographically and politically. Two states were eliminated from this list for being too advanced. This yielded five states selected for site visits.

Visits were arranged for 2 ½ days of interviews with as many people as possible who could offer important information about policy barriers and opportunities for intervention. The goal was to include key legislators and legislative staff that chair or staff health committees or health appropriations, or who are leaders on oral health issues; maternal and child health, disability and/or oral health advocates; the state dental board; the state dental association; the state hygiene association; local or state executives from foundations that support oral health programs; community health center or dental clinic representatives; SCHIP and Medicaid directors and dental officers; the state dental director from the health department; and faculty from dental and hygiene schools. It wasn't possible to meet with every representative in each state given time restrictions and scheduling conflicts.