



ABOUT TRENDNOTES

TRENDNOTES, published semi-annually by The National Maternal and Child Oral Health Policy Center, is designed to highlight emerging trends in children's oral health and promote policies and programmatic solutions that are grounded in evidence-based research and practice. It focuses policymakers' attention on the trends, opportunities and options to improve oral health for all children at lower cost through the best use of prevention, disease management, care coordination, and maximized resources.

This issue of TRENDNOTES provides an overview of the oral health provisions contained in the Patient Protection and Affordable Care Act (ACA). Additionally, it discusses the opportunities presented by ACA, including how ACA builds on provisions included in the reauthorization of the Children's Health Insurance Program (CHIPRA), to build and strengthen a comprehensive system of oral health for children.

Future TRENDSNOTE:

Because TRENDNOTES is a publication that strives to be relevant to current policy issues, we welcome your comments, feedback, and suggestions for future issues.

Contact us at (202) 833-8388 or send us a comment through the Policy Center website: www.nmcohpc.org.

Opportunities for Preventing Childhood Dental Caries through Implementation of Health Care Reform

Trend

The Affordable Care Act (ACA), signed into law on March 23, 2010, is designed to provide insurance coverage to 32 million uninsured Americans, institute sweeping reforms to the insurance industry, and make new investments in public health and prevention. The law includes more than 20 provisions to promote oral health and prevent dental caries in children. Most notably, Congress mandated pediatric dental coverage and supported this mandate by underscoring the importance of a comprehensive systems approach to oral health. This approach includes provisions regarding dental caries prevention, a strong dental health care workforce, and quality care. Support to carry out these provisions will become available to states as appropriations are made and programs are formulated by federal agencies through rules, regulations and the federal grant making process.

Policy Solutions

1. Turn opportunities into action: Encourage federal appropriations for the multiple ACA oral health provisions and grant programs for states.
2. Prepare for new federal grant opportunities: Monitor new grant programs authorized by ACA and develop strategies that will adequately position states and communities to apply for grants as they become available.
3. Integrate oral health across new programs: Ensure that new ACA programs and investments (e.g., home visiting) include attention to oral health and are coordinated with and/or integrated into comprehensive systems of oral health care.
4. Target new FQHC and SBHC opportunities: Ensure that expansions to Federally Qualified Health Centers (FQHCs) and School-based Health Centers (SBHCs) include dental services. Join with dental associations and other groups to actively promote contracting between private practice dentists and health centers as supported by CHIPRA.
5. Align state practice acts with new programs: Modify dental practice acts to qualify for the ACA Alternative Dental Health Care Provider Demonstration Grants.
6. Partner effectively: Develop and strengthen partnerships with key advocacy and service agencies and organizations (e.g., early childhood, child welfare, perinatal) to ensure that oral health is a core component of health care reform implementation at the state and local level.
7. Strengthen state oral health agencies: Empower and support state dental directors to coordinate, integrate, and promote oral health actions arising from ACA.

Why is Health Care Reform Significant to Children's Oral Health?

When the landmark health care reform legislation, the Affordable Care Act (ACA), was passed and signed into law in March 2010 our nation's leaders recognized the importance of oral health to children's overall health. More than 20 oral health provisions were included in the law, most notably a requirement that pediatric health care coverage include dental care and a prohibition against any cost-sharing (e.g., co-pays) for preventive services. ACA's pediatric dental benefit and private insurance benefit design requirements, together with the new Children's Health Insurance Program (CHIP) dental requirement and the longstanding Medicaid EPSDT dental mandate, assure that nearly every child in America who is a U.S. citizen will gain access to dental coverage over the coming years. Finally, the law helps states and communities improve oral health in a comprehensive, systematic way by authorizing programs to educate families about the importance of children's oral health, strengthen the dental care workforce, and improve oral health data collection and reporting by federal and state authorities.

Despite the concerted attention that ACA brings to improving the oral health of children, dental coverage for low-income adults remains an optional benefit that is determined by states. This has significant implications for pregnant women – a population for which there are significant opportunities to reduce dental caries transmission to their children. ACA provides states the opportunity to enhance dental

To understand the opportunities and potential impact of the ACA oral health provisions for improving the oral health of children and pregnant women, it is important to consider them together with the dental care provisions that were established as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Many of the CHIPRA provisions are critical stepping-stones for what was subsequently included in ACA. Taken together, ACA and CHIPRA establish an important framework for building a comprehensive oral health system at the national, state and local level.

The Disease Basics of Childhood Dental Caries

Dental caries is a chronic, infectious disease caused by bacteria that are found in the mouth and transmissible from caretakers, particularly mothers, to children. When sugar and other complex carbohydrates are consumed, the bacteria produce acid that removes protective minerals (enamel) from the surface of the tooth (demineralization). If left undisturbed because of poor oral hygiene practices in combination with significant and frequent sugar intake, the bacteria can increase and over time, cause a cavity to form. In fact, the frequency of sugar intake not only feeds the cavity process but furthers the growth of decay-causing bacteria. The progression of dental caries depends on the balance of protective factors (e.g., saliva, fluoride) and disease factors in the mouth.

Dental caries is preventable and with appropriate early intervention and ongoing management, can actually be reversed. Preventive measures such as fluoride and dental sealants can prevent tooth decay. Fluoride reduces the ability of the bacteria to produce acid and promotes the remineralization of enamel, thereby preventing a cavity from continuing to form. Dental sealants are protective coatings applied to the chewing surfaces of teeth, typically in school-age children, to prevent tooth decay.

Sources: Exactly what is "Dental Caries"? Building a Definition from Research Washington, DC: Children's Dental Health Project. Morbidity and Mortality Weekly Report. Recommendations for using fluoride to prevent and control dental caries in the United States. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. August 17, 2001/50(RR14);1-42.

Childhood tooth decay is the number one chronic health condition of childhood; disease rates are on the rise among young children for the first time in 40 years.

benefits for adults at minimal to no cost initially: states can provide dental benefits for newly Medicaid eligible adults at no cost to the state from 2014-2019 (100% FMAP)¹.

Many of the ACA oral health provisions respond to longstanding priorities of the National Maternal and Child Oral Health Policy Center. The Policy Center and child health advocates are working to improve the oral health of children by advancing policies and programs that help states and communities build a comprehensive, integrated system of care to promote optimal oral health in children and prevent early childhood dental caries. (See the text box and Figure 1 for an overview of key elements of a comprehensive system of oral health.) The ACA provisions are a significant accomplishment as they place an emphasis on preventing childhood dental caries as well as early detection to prevent early stage caries from progressing to more severe stages that require high cost restorative care.

The Significance of Health Care Reform to Children's Oral Health, Continued

ACA is first and foremost a health coverage bill. As such, it underscores the commitment of our nation's leaders to children's oral health by requiring that pediatric dental care be included in the required "qualified benefits" package. However, unlike the long-standing pediatric dental coverage in Medicaid EPSDT and the specific dental requirements in CHIP, the details of the new ACA dental benefit for children will be specified through federal regulation and decisions made by the state-based Exchanges, leaving room for interpretation about the scope of the benefit.

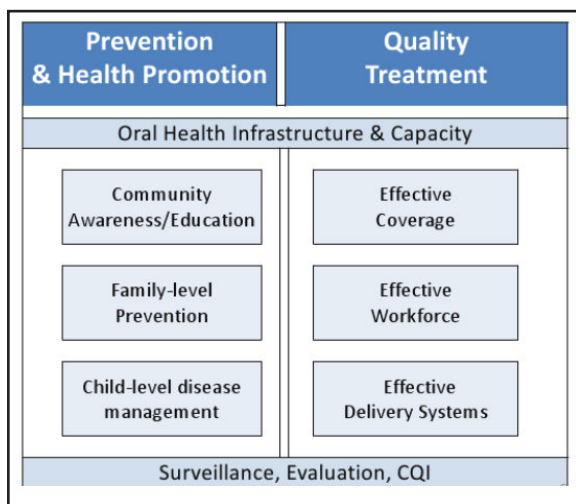


Figure 1: Overall Infrastructure for Improving Oral Health

Finally, this new coverage is supported by a host of additional provisions that seek to ensure that the coverage is effective by addressing:

- funding of programs and services,
- workforce preparation and sufficiency,
- safety net expansions,
- prevention, and
- accountability.

A table highlighting the ACA oral health provisions, funding and timelines is on page 8.^{2,3}

Policymakers have numerous opportunities to further underscore the importance of children's oral health through the implementation of ACA. First, it is critical that policymakers consider the experience of existing public (e.g., Medicaid and CHIP) and private dental coverage when making determinations about the scope of the dental benefit for children as part of ACA regulations. Second, many of the ACA provisions lack dedicated funds through federal appropriations to support the activities. Finally, there are numerous details related to grant programs and other provisions in ACA that will need to be addressed by federal regulators in the coming months and years.

Core Elements of a Comprehensive System of Oral Health for Children and Pregnant Women

The core elements of a comprehensive system to promote optimal oral health in children and to prevent early childhood dental caries include:

- + **Access, Coverage and Financing:** Ensuring that children have access to comprehensive public and private dental coverage and that financing mechanisms for dental care programs and services are in place and adequate to:
 - *meet the needs of pregnant women, infants, children, and teens, and*
 - *engage dental and non-dental providers in delivering care to all children, including those with special health care needs.*
- + **Prevention:** Promoting optimal oral health in children at an early age by:
 - *establishing a dental home at 1 year of age,*
 - *identifying high-risk children and developing disease management plans tailored to their needs, and*
 - *educating pregnant women, new moms and other caregivers about the importance of children's oral health and how to prevent the transmission of dental caries.*
- + **Workforce and Training:** Building and maintaining a well-trained dental workforce with sufficient capacity to meet the needs of children and their families, and engaging non-dental primary healthcare providers to assess risk, counsel families, provide preventive services including fluoride varnish, and make effective referrals.
- + **Oral Health Infrastructure, Monitoring and Quality:** Assuring that the infrastructure to support oral health programs and services (e.g., staffing, training, safety net facilities) and data systems are in place and sufficient to track, monitor and report on dental services and oral health outcomes to improve the quality of prevention programs and dental care services.
- + **Linkages with Child-Serving and Perinatal Programs and Systems:** Creating linkages between:
 - *private and public programs and systems, including early intervention, home visitation, primary care, child care, schools, Head Start, and WIC, and*
 - *public and private dental delivery systems.*

What are the Oral Health Provisions in Health Care Reform?

Access, Coverage, & Financing

Oral health services are required for all children ages birth-18 under Medicaid, the Children's Health Insurance Program (CHIP) and as part of the state Health Insurance Exchanges mandated by ACA. The reauthorization of CHIP required that states provide dental coverage for CHIP beneficiaries – a benefit that had been “optional” for states with separate CHIP programs prior to CHIPRA. CHIPRA also allows states to provide optional supplemental dental coverage that “wraps” around commercial medical coverage for children who are income-eligible for CHIP but whose health insurance does not include a dental care benefit. Comprehensive preventive and restorative dental services were already required under Medicaid as part of the program's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and, therefore, extend to children who receive CHIP benefits through a Medicaid expansion.

The Affordable Care Act includes more than 20 provisions on oral health, most notably a requirement that pediatric coverage under state Insurance Exchanges include dental care.

ACA's dental coverage, financing, and access provisions:

- Require pediatric dental care in new coverage and prohibit cost-sharing: The “essential health benefit package” to be offered in the state Exchanges includes “pediatric services, including oral care.” Preventive dental services must be offered without associated cost sharing from deductibles or co-payments.
- Extend EPSDT's dental care to children newly gaining Medicaid coverage: EPSDT requires that states, in consultation with dental authorities, develop periodicity schedules that promote early and effective intervention and that any oral health service required by a child be a covered benefit.
- Allow dental-only insurance plans to offer coverage in the state Exchanges: Families will have the option of purchasing their children's dental coverage as part of a health plan or as a separate dental plan offered by “stand-alone” dental insurers.
- Charge MACPAC to address financing: The Medicaid and CHIP Payment and Access Commission (MACPAC) is charged with reviewing and reporting to Congress on payment rates for health professionals, including dental professionals.
- Increase access through FQHCs and SBHCs: The Federally Qualified Health Center (FQHC) network is expanded and enhanced through additional funding that can support dental

program expansions, including contracting with private dentists. Provisions for School Based Health Centers (SBHC) include specification of oral health care as qualified services. Of the more than 1,900 school-based health centers currently operating nationwide, the majority offer dental education but less than one quarter provide dental examinations, sealants and screenings and less than one tenth provide reparative dental services to students.

Health Insurance Coverage under the Affordable Care Act

The Affordable Care Act is designed to provide health insurance coverage to more than 32 million uninsured people through four core mechanisms, most of which go into effect January 1, 2014. The law:

- Expands Medicaid coverage to all non-elderly people with incomes up to 133 percent of the Federal Poverty Level (FPL) and ends categorical eligibilities.
- Preserves Medicaid and CHIP coverage for children above 133 percent of the FPL.
- Creates state Insurance Exchanges so that individuals and small businesses can purchase “essential health insurance packages” through private insurance companies or multi-state health plans.
- Provides tax credits to help people with incomes up to 400 percent FPL purchase insurance in state Exchanges.

Source and for more information visit: www.healthcare.gov.

Health Care Reform?



Oral Health Provisions in Health Care Reform, Continued

Prevention

Congress underscored the importance of preventing childhood dental caries through several ACA provisions, including a requirement for a national public education campaign on oral health. Under the law, the Secretary of Health and Human Services (HHS) is charged with establishing a five-year, evidence-based public education campaign to promote oral health. The campaign must include a focus on early childhood caries, prevention, the oral health of pregnant women, and the oral health of at-risk populations. This campaign augments a CHIPRA requirement that oral health education materials be provided to new parents of CHIP enrollees about the risks for and prevention of early childhood caries.

Additional ACA dental prevention and disease management provisions:

- Establish an Early Childhood Caries (ECC) management demonstration program: Community dental providers, including FQHCs, SBHCs, health departments, hospitals, and dental care providers qualify for research-based ECC management demonstration grants. This provision addresses dental caries as a preventable and manageable disease and builds support for development of financing incentives that reduce risk and caries experience rather than dental repair.⁵
- Expand support for school-based dental sealant programs: ACA expands beyond 19 states (the 16 noted below plus three to be funded by September 1, 2010) the number of states that may receive federal (CDC) grants to strengthen their oral health programs, including development of school-based sealant programs.⁶

Work Force and Training

ACA's dental coverage alone would be inadequate to improve access to dental care given the GAO's finding that "several factors contribute to the low use of dental services among low-income persons who have coverage; the major factor is difficulty finding dentists to treat them."⁷

For instance, dental care utilization is low for Medicaid enrollees even though these children are individually entitled under federal law to comprehensive preventive and restorative dental services. In many states, few dentists accept clients enrolled in Medicaid and CHIP, commonly citing low reimbursement rates, complex forms, and burdensome administrative requirements as their reasons for not participating in these programs.^{8,9}

ACA establishes several provisions to improve the types, numbers, qualifications, and availability of the dental care workforce. These provisions are:

- Create a National Health Care Workforce Commission with attention to the capacity of the dental workforce: The Commission will study and make recommendations to Congress on assuring a qualified health care workforce with sufficient capacity to meet the needs of Americans, including the sufficiency of the dental workforce.
- Expand federal training support for primary care dentistry: The authorization for dental workforce training was expanded from \$7 million to \$30 million. Training was expanded to include dental hygienists in addition to general, pediatric and public health dentists. Finally, federal training support was designated for a unique appropriations line item that separates Congressional primary care funding for dentistry from medicine.
- Target primary care dental training to the needs of underserved populations: Congress focuses dental training on preparing dentists and hygienists to care for underserved populations with the greatest disease experience through pre-doctoral and continuing dental education programs; financial aid to students; incentives to integrate dental with medical care; and technical assistance in focusing programs on highest risk children.
- Enhance dental education capacity: Faculty development and loan repayment programs encourage capacity development in the fields of public health, pediatric dentistry, general dentistry, and dental hygiene.



Oral Health Provisions in Health Care Reform, Continued

Work Force and Training, Continued

- Institute a new alternative dental provider demonstration program: Congress authorized \$20 million over five years for up to 15 states to demonstrate the development and employment of new dental providers to address the needs of underserved populations and charged the Institute of Medicine with conducting an evaluation of these efforts. Some states have responded to access problems by expanding the scope of practice for dental hygienists and dental assistants in addition to piloting new types of dental professionals such as dental therapists. However, the law requires that these demonstrations comport with state practice acts leaving needed action in states to allow for such experimentation.
- Create a pre-doctoral Public Health Sciences Track for healthcare providers including dentists: The Secretary of DHHS is authorized to designate and fund educational programs and students – including 100 dental students annually – to tailor studies to “team based services, public health, epidemiology, and emergency preparedness and response.” Graduates will be required to serve in the U.S. Public Health Service (two years for each year of federal educational support up to 8 years).
- Increases post-doctoral dental training support: ACA increases funding for new and expanded primary care residency programs and increases Graduate Medical Education support for hospital-based programs, including post-doctoral dental programs.

Oral Health Infrastructure, Monitoring and Quality

The ultimate goals of health reform are to improve health status and quality of care. As such, ACA includes several provisions to monitor Americans’ oral health status, measure the use of dental services, and increase accountability in governmental programs. These provisions augment previous Medicaid, CHIP, and Maternal and Child Health Block Grant state reporting requirements that measure the number of children who receive various levels of dental services and who receive dental sealants.

ACA provisions related to quality and oral health surveillance:

- Provide all states, U.S. jurisdictions and territories, and American Indian tribes support for oral health infrastructure: This provision expands from 19 to all states and jurisdictions the number of state agencies whose oral health programs will, upon sufficient appropriations, receive CDC support for program infrastructure development including development of state-level oral health plans, leadership development, policy development, partnerships and coalition development, sealant programs, and community water fluoridation programs.
- Improve national surveillance, monitoring and reporting on the oral health status and dental care of Americans: The DHHS Secretary is charged with updating and improving national oral health surveillance through several existing national data systems:
 - » Pregnancy Risk Assessment and Monitoring System (PRAMS): ACA mandates oral health and dental care surveillance of pregnant women in this ongoing state-level survey. This provision highlights the importance of maternal oral health on the oral health of children while also assessing the experience of women during pregnancy.
 - » National Oral Health Surveillance System (NOHSS): ACA requires a new measure of early childhood caries prevalence in this system that monitors oral disease burden in the states. It also provides funding to expand NOHSS to all states.
 - » National Health and Nutrition Examination Survey (NHANES): ACA reverses Agency plans to reduce the level of detail in oral health surveillance, thereby preserving NHANES’ capacity to track trends in childhood and adult tooth decay and other oral conditions.
 - » Medical Expenditure Panel Survey (MEPS): Provides the ability of MEPS to validate the data collected on use of dental services and associated costs similar to the ability to validate medical expenses.



Other ACA Provisions that can Improve the Oral Health System

In addition to coverage, financing, access, prevention, workforce, infrastructure, and surveillance provisions specific to oral health and dental care, ACA institutes broad health system reforms and investments that may present additional opportunities for improving Americans' oral health. These include the:

- Home Visitation program: This \$1.5 billion, five-year program builds on proven models for home-based early intervention to maximize the health, development and well-being of at-risk infants and has the potential to include a focus on oral health.
- Prevention and Public Health Trust Fund: This \$75 billion per year program provides an expanded and sustained national investment in prevention and public health programs that may include attention to oral health.
- Health Homes in Medicaid Program and State Grants to Promote Community Health Teams: These two programs authorize state planning grants to develop state plan amendments that provide health homes in Medicaid and to develop teams to serve patients' needs. Both may involve oral health and dental care.
- Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services (CMS): This new federal Center will test innovative payment and service delivery models for Medicare, Medicaid and CHIP.
- Community-Based Collaborative Care Network Program: ACA authorizes support for consortia of health care providers, which may include dentists, to coordinate and integrate health services for low-income uninsured and underinsured individuals.

Taken together, these ACA provisions support the comprehensive systems approach to improving Americans' oral health featured in Figure 1. These provisions not only recognize the importance of dental coverage, at least for children, but also provide the essential infrastructure needed to ensure that services become available and are delivered by well trained oral health professionals in a variety of settings. Almost all ACA oral health provisions provide specific opportunities to state policymakers to expand the availability of dental care and improve its quality, advance the promotion of oral health, and monitor the performance of new and expanded programs.

Conclusion

Health care reform will result in dramatic increases in health insurance coverage, including pediatric dental coverage, together with sweeping changes to the nation's health care delivery system. The oral health provisions of the Affordable Care Act are a significant accomplishment for leaders and advocates in the oral health community yet much work remains to be done. The details of these provisions still need to be specified in by federal officials. In addition, Congress will be watching to determine if these actions meet Congressional intent. Finally, much of health care reform implementation, particularly the architecture of health



Table 1. Highlights of Key Oral Health Provisions in the Affordable Care Act (ACA)¹

	PROVISION	OVERVIEW	FUNDING	TIMELINE
ACCESS, COVERAGE & FINANCING	Oral Health Services for Children SECS. 1302b and 2713	Requires State Exchanges to include oral health services and prohibits cost-sharing for preventive services.	Required	2014
	Oral Health Services and SBHCs SEC. 4101	Provides grants to school-based health centers and includes oral health services in qualified services to be provided by the centers.	Authorized	2011
	Stand Alone Dental Plans SECS. 2707, 1402 and 1401	Allows stand-alone dental plans with pediatric dental benefits to participate in State Exchanges. Cost-sharing protections may not be imposed on stand-alone dental plans. Beneficiaries can use their tax subsidy for Stand Alone Dental Plans.	Required	2014
	MACPAC Reporting on Dental Payments SEC. 2801	Requires MACPAC to review and report to Congress on payments to dental professionals.	Required	2010
PREVENTION	Medicare Advantage SEC 3202	Requires Medicare Advantage Plans to use rebates to pay for dental coverage and other services.	Required	2012
	Dental Caries Disease Management SEC. 4102, SEC. 399LL-1	Establishes a national grant program to demonstrate the effectiveness of research-based dental caries disease management.	Authorized	2010 – 2011
	School-based Dental Sealant Programs SEC. 4102	Requires that states receive grants for school-based dental sealant programs.	Authorized	2010 – 2011
	Oral Health Public Education Campaign SEC. 4102	Requires the Secretary of HHS to establish a five-year, comprehensive, evidence-based public education campaign to promote oral health.	Authorized	2010 – 2012
	Prevention and Public Health Trust Fund SEC. 4002	Establishes a fund to provide an expanded and sustained national investment in prevention and public health programs which may include oral health. ²	Required	2010-2011

¹ Adapted from the Children's Dental Health Project publication, Summary of Oral Health Provisions in Health Care Reform which is accessible at: http://cdhp.org/resource_health_care_reform_toolbox. Legislative language from the Patient Protection and Affordable Care Act is included in this document.

² For more information on the Prevention and Public Health Trust Fund, visit the Trust for America's Health: <http://healthyamericans.org>

Table 1.2. Highlights of Key Oral Health Provisions in the Affordable Care Act (ACA), Continued

	PROVISION	OVERVIEW	FUNDING	TIMELINE
WORKFORCE AND TRAINING	Alternative Dental Health Care Providers SEC. 5304	Establishes a demonstration project in 15 sites to train or employ alternative dental health care providers.	Authorized	2011 – 2012
	National Health Care Workforce Commission SEC. 5101	Establishes the Commission and makes the oral health care workforce a high priority area for review.	Authorized	2010 – 2011
	Dental Training Programs SEC. 5303	Establishes a number of provisions to promote and encourage the training of dental professionals including loan repayment programs for dental providers.	Authorized	2010 – 2011
ORAL HEALTH INFRASTRUCTURE, MONITORING AND QUALITY	Primary Care Residency Programs SEC. 5508	Establishes three-year, \$500,000 grants to establish new primary care residency programs, including dental programs.	Authorized	2010 – 2011
	Graduate Medical Education Programs SEC. 5508	Provides funding for new and expanded graduate medical education, including dental education.	Authorized	2010 – 2011
	Oral Health Infrastructure SEC. 4102	Requires the Centers for Disease Control and Prevention to provide cooperative agreements to states for improving oral health infrastructure.	Authorized	2010-2011
	Pregnancy Risk Assessment and Monitoring System (PRAMS) SEC. 4102	Requires that oral health measurements be included in PRAMS.	Authorized	2010 – 2011
	National Health and Nutrition Examination Survey (NHANES) SEC. 4102	Requires that oral health components be included in NHANES.	Authorized	2010 – 2011
	National Oral Health Surveillance System (NOHSS) SEC. 4102	Requires that the NOHSS include measurement of early childhood caries and authorizes funding to expand the system from 16 States to all 50 States.	Authorized	2010 – 2011

HIGHLIGHTS

Opportunities for Preventing Childhood Dental Caries through the Patient Protection and Affordable Care Act

The Affordable Care Act (ACA) is designed to provide insurance coverage to 32 million uninsured Americans, institute sweeping reforms to the insurance industry, and make new investments in public health and prevention. The law includes more than 20 provisions to promote oral health and prevent dental caries in children most notably, a mandate for pediatric dental coverage and provisions that underscore the importance of a comprehensive systems approach to oral health. Support to carry out the ACA provisions will become available to states as appropriations are made and programs are formulated by federal agencies through rules, regulations and the federal grant making process.

The oral health provisions of ACA are a significant accomplishment for leaders and advocates in the oral health community yet much work remains to be done. Leadership at the national, state and local levels is critical to advance the oral health provisions and ensure that oral health remains a priority of health care reform. Strategies to advance the ACA provisions include:

- 1. Turn opportunities into action:** Encourage federal appropriations for the multiple ACA oral health provisions and grant programs for states.
- 2. Prepare for new federal grant opportunities:** Monitor new grant programs authorized by ACA and develop strategies that will adequately position states and communities to apply for grants as they become available.
- 3. Integrate oral health across new programs:** Ensure that new ACA programs and investments (e.g., home visiting) include attention to oral health and are coordinated with and/or integrated into comprehensive systems of oral health care.
- 4. Target new FQHC and SBHC opportunities:** Ensure that expansions to Federally Qualified Health Centers (FQHCs) and School-based Health Centers (SBHCs) include dental services. Join with dental associations and other groups to actively promote contracting between private practice dentists and health centers as supported by CHIPRA.
- 5. Align state practice acts with new programs:** Modify dental practice acts to qualify for the ACA Alternative Dental Health Care Provider Demonstration Grants.
- 6. Partner effectively:** Develop and strengthen partnerships with key agencies and organizations (e.g., public health, early childhood, child welfare) to ensure that oral health is a core component of health care reform implementation at the state and local level.
- 7. Strengthen state oral health agencies:** Empower and support state dental directors to coordinate, integrate, and promote oral health actions arising from ACA.



About the National Maternal and Child Oral Health Policy Center

The National Maternal and Child Oral Health Policy Center was created in 2008 with support from the Maternal and Child Health Bureau as a collaborative effort of the Association of Maternal and Child Health Programs (AMCHP), Association of State and Territorial Dental Directors (ASTDD), Children's Dental Health Project (CDHP), Medicaid/SCHIP Dental Association (MSDA), and National Academy for State Health Policy (NASHP). The Policy Center, which is housed at CDHP, promotes the understanding of effective policy options to address ongoing disparities in children's oral health. The three-year initiative has set out to map a course for improving family oral health by building knowledge and skills of professionals with the ability to steer systems changes. Please visit the Policy Center website at <http://nmcohpc.org>.

Acknowledgements

This **TRENDNOTE** was written by Karen VanLandeghem, MPH, Health Policy and Program Consultant. Children's Dental Health Project (CDHP) Chair and Founding Director, Burton Edelstein, and CDHP staff provided invaluable content, guidance and support in the development of this **TRENDNOTE**.

The National Maternal and Child Oral Health Policy Center would also like to thank our partners at AMCHP, ASTDD, MSDA, and NASHP for their thoughtful input.



Feedback for Future TRENDNOTES Topics:

The National Maternal and Child Oral Health Policy Center covers emergent and emerging trends in children's oral health to educate policymakers and to advance policies and practices that improve oral health for all children, including those with physical and social vulnerabilities. To provide your feedback to this publication and submit ideas for future **TRENDNOTES** please go to: <http://www.nmcohpc.org/feedback>.

For Further Information:

The Policy Center would like to know how policymakers are using **TRENDNOTES** and hear about additional topics of interest. To help inform future **TRENDNOTES** topics and for more information about children's oral health or this **TRENDNOTE** please contact: Colin Reusch, Project Associate, Children's Dental Health Project, at (202) 833-8288 or creusch@cdhp.org.

Endnotes

¹ Edelstein B and Mullin L. Oral Health Provisions in CHIPRA and Healthcare Reform: A "Systems Fix" Approach. Washington DC: Children's Dental Health Project. April 2010. Accessible at: <http://www.cdhp.org/system/files/CDHP%20NASHP%20final%20adobe.pdf>.

² Summary of Oral Health Provisions in Health Care Reform. Washington, DC: Children's Dental Health Project. 2010. Accessible at: http://cdhp.org/resource/health_care_reform_toolbox.

³ CHIP Reauthorization: Renewed Support for Children's Oral Health. Washington, DC: Children's Dental Health Project. 2009. Accessible at: http://cdhp.org/resource/chip_reauthorization_renewed_support_children%E2%80%99s_oral_health.

⁴ Strozer J, Juszczak L, and Ammerman A. 2007-2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care. 2010.

⁵ VanLandeghem K. Better Health at Lower Costs: Policy Options for Managing Childhood Tooth Decay. Washington, DC: National Oral Health Policy Center, Children's Dental Health Project. October 2009.

⁶ Centers for Disease Control and Prevention, Division of Oral Health. CDC-Funded States. Accessed 7/6/10 at: http://www.cdc.gov/oralhealth/state_programs/cooperative_agreements/index.htm.

⁷ U.S. General Accounting Office. Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations. GAO/HEHS-00-149. Washington, D.C.: September 11, 2000.

⁸ Edelstein B. Barriers to Medicaid Dental Care. Washington, DC: Children's Dental Health Project. 2000. Accessed 7/1/10 at: http://www.cdhp.org/resource/barriers_medicaid_dental_care.

⁹ Krol D. and Wolf JC. Physicians and dentists attitudes toward Medicaid and Medicaid patients: review of the literature. Columbia University. 2009.