

Policy Benchmark 1: Having sealant programs in at least 25 percent of high-risk schools

Percentage of high-risk schools with sealant programs, 2010	Number of states
75-100%	2
50-74%	7
25-49%	12
1-24%	23
None	7

Dental sealants are clear plastic coatings applied to the chewing surfaces of molars (the most cavity-prone teeth) that block food and bacteria from gathering in the deep grooves of back teeth, preventing 60 percent of decay at one-third the cost of filling a cavity.¹⁷ Dental sealant programs targeting schools with many high-risk children have been recommended by the U.S. Task Force on Community Preventive Services.¹⁸



Pew surveyed each state to determine what portion of its high-risk schools was reached by school-based or school-linked sealant programs in the 2009-10 school year. In 23 states, these programs reached fewer than one-quarter of the highest-need schools, and seven states reported having no school-based programs at all.

Policy Benchmark 2: Allowing a hygienist to place sealants in a school-based program without requiring a dentist's exam¹⁹

State allows hygienist to provide sealants without a dentist's prior exam, 2010	Number of states
Yes (Exam never required)	16
Yes (Exam sometimes required - for example, certain classifications of hygienist can place sealants without a prior exam)	13
No (Exam always required)	12
No (Exam and dentist's direct or indirect supervision required)	10

Sealants prevent decay by serving as a barrier between a tooth and cavity-causing bacteria. Sealants also impede the growth of cavities, heading off the need for expensive fillings.²⁰

Dental hygienists are the primary providers for school-based sealant programs. The cost of these programs and how many children they serve depend partly on whether states have unnecessary hurdles that interfere with hygienists' ability to place sealants on kids' teeth. One such obstacle is the requirement

that children are examined by a dentist before sealants can be applied. State laws vary greatly in this area and many do not reflect the scientific consensus that x-rays and other advanced diagnostic tools are unnecessary to determine the need for sealants.²¹

During the past year, North Dakota and Massachusetts made meaningful policy changes that broaden hygienists’ ability to place sealants in public health settings.

Policy Benchmark 3: Providing optimally fluoridated water to at least 75 percent of residents who are served by public systems

Percentage of population on community water supplies receiving optimally fluoridated water, 2008	Number of states
75% or greater	28
50–74%	14
25–49%	7
Less than 25%	2

Through community fluoridation, water engineers adjust the level of fluoride to the optimal level to reduce tooth decay. Fluoridation stands out as one of the most effective public health efforts that the United States has ever undertaken.²² Fluoridated water reduces decay rates for children and adults by between 18 and 40 percent, avoiding the need for costly corrective dental treatments.²³ As a result, for most cities, every \$1 invested in this preventive measure produces roughly \$38 of savings in dental treatment costs.²⁴

When the U.S. Department of Health and Human Services (HHS) recently lowered its recommended fluoride level in drinking water, a handful of critics misrepresented the announcement as a reason to fear fluoridated water. Yet the recommendation simply reflects the fact that Americans are getting fluoride through various products, such as toothpaste and mouth rinses, that weren’t commonly used when the fluoride level was set initially. In its announcement, HHS reinforced its view of the health benefits that result when public water systems optimally fluoridate drinking water.²⁵

Recent data from the CDC show that as of 2008, fluoridation is reaching 72 percent of residents served by community water supplies, and 64 percent of the total U.S. population.²⁶ Pew found that 28 states succeeded in bringing fluoridated water to at least 75 percent of its citizens on public supplies, with the addition of Delaware and Oklahoma since 2006. Although California falls short of the national benchmark, the state now provides fluoridated water to more than half of its citizens since cities such as San Diego have begun fluoridating. By contrast, New Jersey and Hawaii fail to reach even 25 percent of their residents.

Policy Benchmark 4: Meeting or exceeding the 2007 national average (38.1 percent) of Medicaid-enrolled children ages 1 to 18 receiving dental services

Percentage of Medicaid children receiving any dental service, 2009	Number of states
59% or greater	2
50–58.9%	9
38.1–49.9%	33
30–38.0%	5
Less than 30%	2

Nationwide, only 44 percent of Medicaid-enrolled children received dental care in 2009 despite a federal requirement that states provide it. That figure continues a trend of modest growth in access nationally, but it still falls far below the 58 percent of privately insured children who use dental services each year.²⁷ (See Exhibit B in the Appendix for state by state Medicaid utilization data since 2000.)

Pew graded states based on whether they exceeded the 2007 national benchmark of 38.1 percent to gauge progress against that baseline. Even with this relatively low bar, seven states failed to meet the threshold.

Florida and Montana provided care to fewer than 30 percent of enrolled children. Thirteen states—Arkansas, California, Delaware, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Jersey, New York, Oregon, South Dakota and Wyoming—and the District of Columbia improved their performance by crossing the threshold of 38.1 percent. Only eleven states—Arkansas, Idaho, Iowa, Massachusetts, Nebraska, New Hampshire, North Carolina, South Carolina, Texas, Vermont and Washington—served more than half of Medicaid-enrolled kids in 2009.

Last year, HHS launched an oral health initiative that included some efforts to help states increase the number of low-income kids who receive care. As one component of the initiative, the Centers for Medicare and Medicaid Services (CMS) reviewed eight state Medicaid programs to identify innovative strategies for improving access. CMS has noted that these new approaches include expanding the roles of existing dental providers and licensing new types of practitioners.²⁸

Despite tough fiscal times, Arkansas raised its grade from an F to a C this year. Learn the story behind Arkansas' solid progress at: www.pewcenteronthestates.org/dental/makingcoveragematter.



In addition, Pew has recommended that state Medicaid programs ensure their reimbursement rates are high enough to cover the cost of care, as well as offer enrollees the support they need to make and keep dental appointments.

This support could include enhancing transportation assistance, offering translation services or providing case management services to help patients navigate the Medicaid system.

DENTAL SERVICES IN THE AFFORDABLE CARE ACT

Through the Affordable Care Act (ACA)—the health care reform law enacted in 2010—at least 5.3 million more children will gain dental coverage by 2014. Most of them will enter Medicaid or CHIP programs that already have difficulty ensuring care to their enrollees.

To make the promise of dental coverage matter for these children, federal and state governments need to adopt policies that support prevention and expand the types of providers available to treat children. States that are seriously committed to improving access must ensure their Medicaid reimbursement rates are high enough to cover dentists' costs—doing so will encourage broader Medicaid participation by dentists.

The ACA authorized, but did not actually fund, grants for all 50 states

and the District of Columbia that support states' ability to advance fluoridation, sealant and data-gathering efforts. The Centers for Disease Control and Prevention (CDC) has used its existing budget to offer grants to 19 states—with Kansas, Texas and Vermont being the most recently funded—but Congress must appropriate funds to make these grants available to additional states.²⁹

The ACA authorized pilot programs for states that wish to introduce new types of dental providers. These programs would allow for the testing and evaluation of various approaches to expanding the dental team, but funding has not yet been secured for these pilots. Likewise, the law authorized, but did not fund, programs to support oral health literacy and additional grants for school sealant programs.

Policy Benchmark 5: Paying dentists who serve Medicaid-enrolled children at least the 2008 national average (60.5 percent) of median retail fees³⁰

Medicaid reimbursement rates as a percentage of dentists' retail fees, 2010	Number of states
90–100%	1
80–89%	2
70–79%	2
60.5–69%	13
50–60.4%	14
40–49%	13
Less than 40%	6

Low-income children have difficulty getting care largely due to a shortage of dentists who are willing to treat Medicaid-enrolled patients. A 2010 Government Accountability Office (GAO) report found that in 25 of 39 reporting states, fewer than half of dentists saw any Medicaid patients.³¹ Dentists point to low reimbursement rates, administrative hassles and frequent no-shows by patients as deterrents to serving them.



In the current fiscal environment, many states have looked to provider reimbursements as a place to cut Medicaid costs, and dental payment rates have not been immune. In 2010, 33 states—an increase from 26 in 2008—reimbursed less than 60.5 cents of every \$1 billed by a dentist. In some cases, this is due to cutbacks, but in others, it is attributable to Medicaid rates not keeping pace with rising dental fees.

Policy Benchmark 6: Reimbursing medical care providers through state Medicaid program for preventive dental health services

Medicaid pays medical staff for early preventive dental health services, 2010	Number of states
Yes	40
No	11

Doctors, nurses, nurse practitioners and physician assistants increasingly are providing preventive dental services to young children. These services include oral health screening and education, application of fluoride varnish (a gel that reduces tooth decay) and referring parents to a dental office when their kids need additional care. Involving medical providers in these ways is especially important since infants and toddlers see these staff earlier and more frequently than they see dentists.

In the past year, more state Medicaid programs—including those in Alaska, Georgia, Mississippi and Pennsylvania—began to reimburse medical providers for delivering preventive dental services, bringing the total to 40. Several other states are considering adopting the policy, and New Hampshire has passed a law (not funded by the time this report was finalized) to enact similar reimbursements.

Policy Benchmark 7: Authorizing a new type of primary care dental provider

State has authorized a new type of primary care dental provider, 2010	Number of states
Yes	1
No	50

Some communities simply do not have enough dentists to meet the needs of all of their residents. Across the 50 states and the District of Columbia, almost 48 million people live in areas identified by the federal government as areas in which there is a shortage of dental health professionals. HHS estimates that it would take more than 6,600 dentists to remove those designations. (See Exhibit C in the Appendix for details on dentist shortages by state.)³²

To close this gap in the oral health workforce, a number of states are exploring new types of allied dental

providers. These professionals would play a role similar to that performed by nurse practitioners in the medical field. Under federal law, dental therapists are serving the needs of Alaska Native Tribes, and similar practitioners will soon begin working in Minnesota—the only state with a law authorizing such providers. (See this [Pew brief](#) for more information on Minnesota’s new providers.) A recent evaluation of dental therapists in Alaska found that they were providing safe, competent care that earned high levels of patient satisfaction.³³

Although no states authorized a new allied dental provider last year, policy makers in many states are exploring the possibility. Public health advocates in Ohio, Kansas, New Mexico, Vermont and Washington have begun developing proposals to add dental therapists to the dental team, and these efforts are being supported by the W.K. Kellogg Foundation.³⁴

Stakeholders in California, Maine and New Hampshire also are working, with support from Pew, to develop proposals that expand the dental workforce.

The Community Dental Health Coordinator (CDHC), a community health worker designed to provide preventive

care and education to families and to assist more people in finding a dentist, is being tested in California, Oklahoma and Pennsylvania. The CDHC pilots are supported by the American Dental Association.³⁵

Legislation to enact an Advanced Dental Hygiene Practitioner—a master’s level degree that would allow hygienists to provide restorative care—was introduced this year in Connecticut, Oregon and Washington.³⁶

Policy Benchmark 8: State submits basic screening data to the national database that tracks oral health conditions

Basic screening data from state posted to the national database, 2010	Number of states
Yes	42
No	9

The ability to collect crucial data is a key element of an effective state dental health program. Without it, states struggle to allocate resources appropriately and

compete for grant funding. Tracking the number of children with untreated tooth decay and the number who have been treated with sealants is essential to crafting state policy solutions and measuring progress.

In the past year, five more states added their data to the National Oral Health Surveillance System, bringing the total to 42.

Unfortunately, eight states and the District of Columbia have never participated in this system. Among the 42 submitting states, the data from 10 are more than five years old, which limits the value of basing decisions on these statistics. ■



Maryland was the top-performing state in Pew’s report on children’s dental health. Learn the story behind Maryland’s success at: www.pewcenteronthestates.org/dental/makingcoveragematter.

