INVITED PAPER

Federal supports for state oral health plans

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Abstract

The past decade has witnessed both a proliferation of state oral health plans that include very specific proposals for action and an emergence of federal laws that include support for oral health. This paper provides an overview of state oral health priorities for action as reflected in 40 oral health plans that were developed independently by states. It examines four federal laws – the 2002 Safety Net Improvement Act, the 2009 CHIP Reauthorization Act, the 2009 economic stimulus law, and the 2010 health reform law – to identify opportunities for alignment with action steps proposed in state plans. This analysis identifies 23 categories of activity proposed by states in their action plans and determines that all but six of these activities are now supported by one or more of these four federal laws. State activities undertaken through grants provided under the 2002 Safety Net Improvement Act are analyzed as an example of how states can leverage federal legislation to advance their oral health plans. The paper concludes with consideration of the steps needed for states to promote their oral health plans by leveraging the full capacity of federal legislation.

Emergence and characteristics of state oral health plans

Between 2002 and mid-2011, 40 states had developed and released one or more state oral health plans. Development of state oral health plans was substantially stimulated by federal grant funding to states from the Department of Health and Human Services – both by the Health Resources and Services Administration's Maternal and Child Health Bureau and the Centers for Disease Control and Prevention's Division of Oral Health. With federal funding and frequent state-level foundation support, collaborations among a wide range of "stakeholders" generated global plans for oral health improvement in almost every state.

The Children's Dental Health Project, with CDC support, collected and analyzed these plans and posted a downloadable *State Oral Health Plan Comparison Tool* and a companion analysis (1). The tool provides information on these plans and includes a link to each plan and to a listing of 23 categories of priority activities found in these plans (Table 1, Column 1). The tool also indicates how each state's plan is reflected in each of those 23 categories.

Although states differ significantly in demography, geography, politics, resources, and economic status, there is surprising consistency across state oral health plans in these priority activities. This finding suggests that the underlying problems and available options are reasonably standard and limited. Nonetheless, there are sufficient nuances and levels of specificity across state action plans that they can serve as valuable resources to advocates in reconsidering and implementing their state-specific strategies.

The remarkable consistency of state plan priorities was also unexpected given the tremendous variation across states in both the processes used to develop plans and the varying levels of community engagement. Endeavors ranged from centralized drafting by a small group of oral health authorities followed by limited public vetting to robust community-wide engagement over many months to develop consensus.

The categories of action identified by the states are consistent with the "10 Essential Public Health Services" identified by the federal Centers for Disease Control and Prevention when applied to dental programs that address oral health of vulnerable populations (2). The categories of priority activity most often addressed by the 40 plans are: access to dental care (93 percent of plans); fluoridation (93 percent); policymaker and public awareness of oral health (90 percent); surveillance, data reporting, and establishing outcomes targets (88

Table 1 Crosswalk between Categories of Activity Articulated by State Oral Health Plans and Congressional Support for Those Activities

State Health Plan Category of Activity	Safety Net Improvement Act (Enacted 2002)	Children's Health Insurance Program Reauthorization Act (CHIPRA) (Enacted 2009)	American Recovery and Reinvestment Act ("ARRA," the Stimulus Recovery Act) (Enacted 2009)	Patient Protection and Affordable Care Act ("ACA") (Enacted 2010)
1 State Leadership	Develop and augment state oral health officer positions		Funds to support state employees	
2 Surveillance/Data Reporting/Outcomes Targets		Performance reporting Quality assurance		
3 Coalitions/Partnerships				
4 Program/Policy Evaluation				
5 Fluoridation	Fluoridation support		Public infrastructure grants	
6 Sealants	Sealant program support			School-based sealant programs expansions
7 Increasing Policymaker & Public Awareness of Oral Health		New parent education Mandatory information for beneficiaries InsureKidsNow website		Public education campaign on oral health
8 Workforce Issues (Recruitment, Retention, Licensure, etc.)	Recruitment and retention grants for dental professionals (students, residents, practitioners) Promote children's involvement in dentistry and science careers			
9 Dental Professional Education	New/expanded residencies in states without dental schools Continued dental education Faculty recruitment		Faculty retention	Title VII dental training expansion
10 Non-Dental Professional Education		Midlevel dental provider study		Title VII extended to hygienist training and therapist demonstration
11 Case Management/Integration of Health Services/Continuity of Care				
12 School-Based/Community-Based Programs	Loan forgiveness for dentists in public health settings			Expansion of school based and federally qualified health centers
13 Access To Care	All provisions	All provisions		Mandatory pediatric dental benefit Premium assistance for low-income families
14 Safety Net/Underserved Areas	Grants/loans to expand private practices and public health programs in underserved areas	Contracting private dentists to FQHCs	Equipment and infrastructure grants	Expansion of school based and federally qualified health centers
15 Cultural Competence of Care				Incentives for faculty and student training
16 Pregnant Women				
17 Early Childhood				Mandatory pediatric dental benefit
18 Seniors				

Table 1 *Continued*

State Health Plan Category of Activity	Safety Net Improvement Act (Enacted 2002)	Children's Health Insurance Program Reauthorization Act (CHIPRA) (Enacted 2009)	American Recovery and Reinvestment Act ("ARRA," the Stimulus Recovery Act) (Enacted 2009)	Patient Protection and Affordable Care Act ("ACA") (Enacted 2010)
19 Tobacco & Alcohol Users/Cancer Prevention				
20 Disabled/Special Needs	New/expand programs to serve children with special needs			
21 Medicaid/Medicaid-equivalent Financing & Care		Wraparound dental coverage for children with medical insurance Medicaid/CHIP information to beneficiaries Medicaid and CHIP Payment and Access Commission	Increased federal portion of Medicaid funding	Medicaid and CHIP Payment and Access Commission expanded authorization
22 General Funding				
23 Other	Teledentistry Distance Education		HITECH medical informatics grants Biomedical and health services research	Caries management grants

percent); workforce issues (88 percent); and sealants (88 percent). The goals and objectives least often addressed in state oral health plans are: state leadership (45 percent); oral health of pregnant women (53 percent); tobacco and alcohol use and cancer prevention (55 percent); culturally competent care (55 percent); oral health services for persons with disability and special needs populations (58 percent); and oral health of seniors (60 percent) (3). Funding for these actions has come from local, state, and federal sources. The latter have had the broadest impact nationally.

Congressional authorizing action of relevance to state oral health plans

In recent years, Congress has enacted four laws that directly affect states' capacity to actualize elements of their state oral health plans. The first, the Health Care Safety Net Amendments of 2002 (PL107-251), authorizes grants to states to pursue one of 12 actions that were selected to improve access to care, particularly in rural areas. The second, the Children's Health Insurance Reauthorization Act of 2009 (PL111-3, "CHIPRA"), continued and refined the 1997 State Children's Health Insurance Program to provide public insurance coverage to children of working-poor families (4). The third, the American Recovery and Reinvestment Act of 2009 (PL111-5, "ARRA," also known as the "stimulus bill" or "recovery bill"), provided immediate funding to a wide range of programs including those important to oral health. The last and most controversial, the Patient Protection and Affordable Care Act of 2010 (PL111-148, "ACA," also known as the "healthcare reform law"), contains over two dozen provisions of direct relevance to oral health and dental care (5). Table 1 details how each of these four laws can support a category of activity in state oral health plans.

As evident in Table 1, most robust support across these four laws are expanded policies and programs for traditional federal involvement in dental professional education (action item 9), access to care (item 13), safety net expansions (item 14), and Medicaid financing (item 21). Added to these considerations is a dramatic increase in support for development and implementation of health information technology (item 23) that holds promise, through "meaningful use," to support patient-centered quality care that is managed through a primary care health home. There is also expansive federal support for building state leadership (item 1), engaging and educating the public about oral health (item 7), training new providers (item 10), and supporting the two evidence-based mainstays of dental prevention – fluoridation (item 5) and sealants (item 6).

Federal legislation is also attentive to surveillance and reporting (item 2), workforce recruitment and retention (item 8), early childhood populations (item 17), and culturally competent care (item 15). The first three have been longstanding concerns of federal government, while attention to cultural contexts of care, like attention to health literacy, social determinants of health, and life course influences on health, has only recently gained traction with policymakers as the social and public health sciences have gained credence from an ever-expanding research base.

Taken together, these four laws provide no explicit or direct support for seven categories of state plan activities: coalitions and partnerships; program and policy evaluation; case management and integration of health services; general program funding; programs targeting pregnant women; programs targeting seniors; and tobacco and alcohol use and cancer prevention. The first four of these activities, however, are process rather than outcome activities and are typically incorporated within other activities. The next three target specific subsets of the population or of oral diseases. Notably, pregnant women and seniors, unlike children and the disabled, are not specifically addressed by these laws. Oral cancer, together with its primary risk factors, is not specifically addressed.

Inherent in most state plans is attention to the availability, breadth, scope, and quality of insurance coverage, both public and private, for oral health services. Since both CHIPRA and ACA are fundamentally health coverage bills, it is notable that both guarantee comprehensive dental coverage for children while neither requires dental coverage for adults, regardless of pregnancy status, special needs, medical indication, or advanced age. CHIPRA reinforces this limitation by disallowing adult coverage altogether (which had been available in a limited way under the 1997 predecessor law). Nonetheless, CHIPRA is progressive in its allowance for states, for the first time, to provide dental coverage for income-eligible children who have commercial medical coverage through their parents' employers but not commercial dental coverage (6). This "dental wrap" constitutes Congressional recognition that essential pediatric oral health services are frequently unavailable to children who enjoy commercial medical coverage. As of October 2011, only Iowa has elected this option through its "Supplemental Dental Only" program (7). ACA dramatically expands Medicaid coverage for an estimated 14 million low-income adults and seniors but continues to defer to states whether to provide dental benefits to adults, and does not include adult oral health services among its enumerated "essential health benefits."

Moving from congressional authorization to support for state plan activities

Key authorizations developed by these four laws must pass through a number of stages before funds become available to support state oral health plan activities. After enactment, new policies and programs require federal agencies to develop regulations and/or program guidance and must be funded through the Congressional appropriations process, a process made increasingly challenging by bipartisan concerns about federal budget deficits, partisan rancor, and reduced federal revenues stemming from the recession that began in 2008. Even when the federal government is functioning smoothly, many months or years may elapse between authorization by Congress and disbursements of funds to states and other grantees. Sometimes funding is never provided or regulatory action lags so long as to reduce the impact of the original authorization.

Oral health provisions authorized by the Health Care Safety Net Amendments of 2002 provide a case in point. These provisions languished for 4 years before appropriations were first made available in 2006 (Table 2) when 18 states benefited from a total of $2.5 M to implement one of the 12 sanctioned activities, all of which appear in state oral health plans. Among funded options in the "Grants to States to Support Oral Health Workforce Activities" program (8) that support state plans are expansion of loan repayment programs, recruitment and retention of dentists in underserved areas, grants and loans to expand existing practices in underserved areas, dental residency expansions, community-based educational and prevention services, and strengthening state oral health departments. Since 2006, the program has grown to 18 states and $2.5 M in 2007, 34 states and $5.0 M in 2008, 25 states and $10.0 M in 2009, and 34 states and $17.0 M in 2010. Table 2 provides information on the states that received funding for various state plan-related activities in 2006 and 2009.

Many key provisions in CHIPRA became effective shortly after enactment. These include the mandate that all covered children receive a comprehensive dental benefit, the requirement that states report on the numbers of children receiving dental services through the Children's Health Insurance Program (CHIP), and the mandate that states provide information to beneficiaries on Medicaid and CHIP participating dentists. However, other CHIP dental provisions (e.g., requirement that new parents receive information on early childhood caries prevention and the appropriateness of early dental care) continue to await regulatory action and implementation.

ARRA, as an economic stimulus effort, sought to fund all of its targeted projects very quickly in order to benefit the economy. As a result, funds became immediately available to expand dental professional education, faculty development, state oral health infrastructure and other related oral health activities. Consistent with all state oral health plans which seek to expand care for Medicaid beneficiaries, Health Information Technology for Economic and Clinical Health Act ("HITECH") provisions within ARRA are designed to incentivize expanded care for Medicaid beneficiaries by providing grants to healthcare providers, including dentists, who purchase and utilize health information technology that meets required standards (9). Utility for dentists, however, has been severely constrained by the lack of "certified" software systems for private practices and by the requirement that dentists must serve at least 30 percent of patients who are enrolled in Medicaid.

Table 2 State Activities in Support of Oral Health Plans Undertaken through Federal Grants Authorized by the Safety Net Improvement Act of 2002

	Activity	Total # of Grant Recipients (2006)	States Addressing Activity (2006)	Total #of Grant Recipients (2009)	States Addressing Activity (2009)
1	Loan forgiveness and repayment programs for dentists who agree to serve as public health dentists	5	AZ, CO, GA, MA. VT	10	CO, DE, GA KS, ME, MA, RI, SD, VA, WA
2	Recruitment and retention efforts	9	AR, CO, DC, ME, MA, MI, MS, RI, VT	15	AZ, AR, CA, CO, DE, FL, KS, KY, LA, ME, MA, MN, NM, PR, SD
3	Grants and low-interest or no-interest loans to expand practices in designated shortage areas	1	NC	2	ME, MA
4	Establish or expand dental residency programs in coordination with accredited dental training facilities in States without a dental school	5	DE, DC, RI, VT, WA	7	AR, DE, GA, KS, MN, RI, WA
5	Programs to establish or expand oral health services and facilities in dental health professional shortage areas, including for children with special needs	18	AL, AR, CO, DE, D.C., FL, GA, LA, ME, MA, MI, MS NC, PR, RI, VT, WA, WI.	24	AZ, AR, CA, CO, DE, FL, GA, IA, KS, KY, LA, ME, MA, MN, NE, NM, OH, OR, PR RI, SD, VA, WA
6	Placement and support of dental students, residents, and advanced dentistry trainees	8	CO, DE, DC, GA, MS, PR, VT, WA	9	CA, CO, GA, IA, KS, MN, PR, WA, WI
7	Continuing dental education including distance-based education	10	AZ, AR, DC, FL, GA, ME, MI, NC, PR, RI	13	AZ, AR, CA, CO, FL, IA, KS, KY, NE, NM, OR, RI, VA
8	Practice support through teledentistry in accordance with existing State laws	1	AZ	2	AZ, CA
9	Community-based prevention services such as water fluoridation and dental sealant programs	8	AZ, DE, LA, MA, MI, NC, PR, WI,	17	AZ, AR, CA, CO, DE, FL, LA, MA, MN, MS, NM, OH, OR, SD, VA, WA
10	Coordination with education systems to promote children going into oral health or science professions	6	AR, DC, ME, RI, VT, WA	5	AR, CA, FL, MN, WA
11	Establish faculty recruitment programs at accredited dental training institutions whose missions include community outreach and service and that have a demonstrated record of serving the underserved	2	DC, MA	1	KS
12	Develop or augment an existing state dental director office to coordinate oral health and access issues in the State	4	DC, LA, MA, MS	21	AZ, AR, CA, CO, FL, IA, KS, KY, LA, ME, MA, MN, MS, NE, NM, OH, PR RI, SD, WA

Source: O'Connor A, Edelstein BL. Analysis of Federal Grants to Support State Oral Health Workforce 2006-2010. Unpublished manuscript.

Efforts to fund the two-dozen oral health provisions in ACA have been subsumed within contentious Congressional debates about the future of that law and about deficit reduction. Among the authorized activities that can support state oral health plans if funding becomes available are grant programs to demonstrate effective caries prevention in young children, expand dental workforce, expand school-based dental services and sealant programs, implement a public oral health education program, and improve surveillance and state oral health infrastructure.

Preparing to take action at the state level

In addition to federal support, policy action at the state level is required to implement state plans. Since many of the plans' proposals require action by state legislators or regulators, the Children's Dental Health Project and CDC developed a "Policy Tool" designed to assist state-level stakeholders in first prioritizing objectives from their long lists of goals and objectives and then negotiating the policymaking process and developing an approach to implementation for a small subset of selected actions. Using the tool and its companion guidebook (10) in facilitated stakeholder meetings, 17 states (as of 2011) have each selected and prioritized actions that meet three criteria: a) addressing a problem that is documented to be extensive, pressing, and consequential; b) widely supported by the community; and c) likely to be effective. State planners have then assessed the difficulty of implementing the selected actions for associated costs, cost-effectiveness, complexity, feasibility, and timing as well as assessment of the strengths and vulnerabilities of potential opponents.

Across the varied states in which the Policy Tool has been used, participants have observed that reaching consensus on prioritization of competing action steps is difficult yet essential; that few actions can be pursued contemporaneously; that leadership, persistence, relationship building, coalition development, and messaging are all required for success; and that political and economic environmental constraints and opposition arguments are often challenging.

Conclusion

Both state-level and federal-level advocacy is needed for states to achieve the priorities designated in their oral health plans. This advocacy must be targeted and persistent. Among the variety of national initiatives that are available to support action steps detailed in state oral health plans, federal initiatives created by four laws spanning 2002 to 2010 provide the most far-reaching opportunities for state oral health advocates because they establish legal authorities or allow for substantive funding. Taken together, these four laws support almost every action proposed by state oral health plans (Table 1). However, before these authorizations and funding streams can reach advocates and states, they must be funded by Congress and implemented by federal agencies. For this reason, oral health advocates in the states need to add yet one more action step to their plans: encouraging Congress to prioritize and support the many oral health provisions it has already enacted.

Conflict of interest

This paper was commissioned by the Maryland Oral Health Coalition. The author declares no other conflicts of interest.

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