Opportunities for Collaboration between State Oral Health Programs and State Medicaid –CHIP Oral Health Programs

Prepared in collaboration by the Association of State and Territorial Dental Directors and the Medicaid - CHIP State Dental Association

This publication was supported by Grant/Cooperative Agreements No.5U58DP001695-05 from the Centers for Disease Control and Prevention to ASTDD and by funding from the DentaQuest Foundation. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of the CDC or the DentaQuest Foundation.

March 2013

Opportunities for Collaboration between State Oral Health Programs and State Medicaid – CHIP Programs to Improve Oral Health

Purpose

Experience in a number of States has shown that strong collaboration between the State Oral Health Program and the State Medicaid – Children's Health Insurance Program (CHIP) Oral Health Program can significantly enhance the success of both programs. The purpose of this document is to help states improve inter-agency collaboration by sharing examples of successful collaboration. It can be used in conjunction with an assessment tool the Association of State and Territorial Dental Directors (ASTDD) and the Medicaid - CHIP State Dental Association (MSDA) have developed to assist State Oral Health Programs and State Medicaid-CHIP Oral Health Programs assess their level of collaboration.

The Importance of Oral Health

In 2000, Oral Health in America: A Report of the Surgeon General, emphasized that oral health is essential to the general health and well-being of all Americans.[1] Dental caries (tooth decay) is the most prevalent chronic disease affecting children, and can lead to pain, systemic infection, poor speech development, difficulty eating, disrupted sleep, and a lack of concentration.[1] Factors that promote oral health disparities include 1) the lack of dental providers in rural areas 2) the lack of Medicaid dental providers, 3) restrictive state dental practice acts, 4) lack of a regular source of dental care, 5) lack of dental insurance, 6) lack of awareness of the importance of oral health to overall health and 7) certain health beliefs.[2] These factors highlight the need for greater collaboration between State Oral Health Program and state Medicaid- CHIP programs to improve oral health.

What is the Association of State and Territorial Dental Directors (ASTDD)?

ASTDD is a non-profit organization representing staff of state public health agency programs for oral health and other partners. Organized in 1948, it is one of 17 affiliates of the Association of State and Territorial Health Officials.

ASTDD's mission is to provide leadership and support to: promote a strong governmental oral health infrastructure and workforce in each state and territory; formulate and promote sound oral health policy; promote evidence-based practices; increase awareness of oral health issues; and assist in developing and implementing initiatives for prevention and control of oral diseases. For more information on ASTDD and membership, visit www.astdd.org.

State Oral Health Programs

Dental public health programs administered by state agencies are termed "state oral health programs." The role of the State Oral Health Program is to improve oral health by increasing awareness of the relationship of oral diseases to systemic health and addressing the *Healthy People 2020* oral health goals to "prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services."[4] State Oral Health Programs with adequate infrastructure and capacity are integral to the mission of state health agencies and strive to accomplish their objectives through strong partnerships and input from stakeholders.

State Medicaid and CHIP Programs

In the US, Medicaid is a government-funded program, which administers and pays for the delivery of healthcare services to low-income individuals and families who meet special population and income eligibility requirements. It is a program that is jointly funded by state and federal governments, and is managed at the state level. Each state Medicaid Program has a dental program administrator who manages the program and oversees program policies and protocols.

The Children's Health Insurance Program (CHIP) is a second government program, which also pays for healthcare services for low-income children and special populations. The State CHIP dental program administers payment for pays for the delivery of oral healthcare services to children and special populations who do not qualify for Medicaid and meet higher income level eligibility requirements.

Oral healthcare services administered by state Medicaid and CHIP dental programs are mandated for children under federal legislation, but are optional for most adults.

What is the Medicaid and CHIP Dental Association (MSDA)?

MSDA is a non-profit organization representing directors, managers and staff of state Medicaid and CHIP Oral Health Programs and individuals and groups who collaborate or have an interest in Medicaid and CHIP Oral Health Programs and their beneficiaries. MSDA's vision is all Medicaid/CHIP beneficiaries receiving quality and cost appropriate oral health care services. Its mission is to promote policies and best practice models that improve Medicaid and CHIP oral health program quality, processes and services. Goals are to strengthen Medicaid and CHIP oral health program infrastructure and capacity to ensure quality and cost appropriate services for optimal health.

MSDA seeks to build and support State Medicaid and CHIP dental program infrastructure and capacity. In so doing MSDA aims to expand state and national leadership; develop sound Medicaid and CHIP oral health program policies and protocols; provide a support system to state and national Medicaid and CHIP dental program representatives; encourage innovation and collaboration among federal, state, local and national Medicaid-CHIP dental program representatives; promote the integration of oral health and primary care in Medicaid and CHIP programs; and promote an appropriate balance between the prevention and treatment of oral diseases and conditions. For more information on MSDA and membership, visit www.medicaiddental.org

A Framework for Considering the Benefits of State Oral Health Program and State Medicaid CHIP Oral Health Program Collaboration

ASTDD and MSDA used the domain framework from the Agency for Healthcare Research and Quality[3] to outline areas for collaboration between State Oral Health Programs and State Medicaid- CHIP Oral Health Programs. The *Healthcare Delivery System* domain framework provides the infrastructure for use by State Medicaid-CHIP Oral Health Programs; while the *Population Health* framework provides the infrastructure for State Oral Health Programs.

Health Care Delivery Measures (State Medicaid-CHIP Oral Health Programs)

Clinical Quality
- Process
- Access
- Outcome
- Structure
- Patient Experience

Related Health Care Delivery
- User-Enrollee Health State
- Management
- Use of Services
- Cost

Clinical Efficiency
- Efficiency

Population Health Measures (State Oral Health Programs)

Population Health Quality Measures
- Population Process
- Population Access
- Population Outcome
- Population Structure
- Population Experience

Related Population Health Measure
- Population Health State
- Population Management
- Population Use of Services
- Population Cost
- Population Health Knowledge
- Social Determinants of Health
- Environment

Population Efficiency Measure
- Population Efficiency

Using these domains as a framework, MSDA and ASTDD have developed an assessment tool State Oral Health Programs and State Medicaid-CHIP Oral Health Programs can use to assess their level of collaboration. Questions are framed around development of policy, data collection and surveillance, outreach and enrollment, fluoride varnish and dental sealant services and program outcome assessment. Each question identifies an opportunity for collaboration. Any "No" or "Don't know" response may identify an opportunity to learn more and identify new opportunities.

The SOHP survey can be accessed at https://www.surveymonkey.com/s/N36QLMD. The Medicaid survey can be accessed at https://www.surveymonkey.com/s/6PYZPDS. Individuals completing the assessment tool for the State Medicaid Oral Health Programs and State Oral Health Programs are encouraged to exchange survey answers and meet with their colleagues to discuss how, together, they can improve their level of collaboration.

Examples of Collaboration

Numerous state examples of State Oral Health Program and State Medicaid-CHIP Oral Health Program collaboration can be found on the ASTDD website in the State Activities section http://www.astdd.org/state-activities/.

Alaska - Medicaid Travel of Pediatric Dental Teams

In Alaska, residents in many communities rely on air or marine transportation to access healthcare, including dental services. In remote locations of Alaska, residents often receive itinerant dental visits with dentists flying, boating or snowmobiling into small communities to deliver dental care – or individuals travel to regional hub communities to access dental care. Like many states, access to dental services for children enrolled in Medicaid, especially new Medicaid clients, is a long-standing problem. To meet dental treatment needs, especially urgent treatment needs, it is not unusual for the child and accompanying adult to use air travel to a hub community or urban community for dental care. The Alaska Medicaid State Plan stipulates that provider travel expenses and per diem may be paid when State Public Health Nurses request this as a means to provide access to services. This was necessary in responding to dental treatment needs identified during EPSDT screenings in several regions within Alaska.

In FY2001, the Alaska Division of Public Health initiated a grant with the Southeast Alaska Regional Health Consortium (SEARHC), a non-profit Native health corporation, to assist with travel and per diem costs for pediatric dental teams traveling in southeast Alaska to deliver services to communities in the region with limited access to Medicaid dental services. The teams provide dental examinations and treatment for children, including non-Native children, enrolled in the Denali KidCare/Medicaid program (Medicaid and CHIP). During the first year of the grant (November 2000 - June 2001), the project provided 1,649 dental visits to more than 900 children enrolled in Medicaid. Medicaid covered all travel related expenses for the project during the first fiscal year; however in SFY 2002-SFY 2003 grant funds covered only about half of the total travel-related expenses with SEARHC covering the balance of these expenses. In SFY2002 605 children enrolled in Medicaid were seen (2,162 Medicaid patient visits in SFY2003). In SFY2004, the project was included in a Medicaid contract (EPSDT continuing care agreement). Currently, the transportation costs are part of the cost settlements as part of the change to a cost-based reimbursement methodology for the Tribal dental programs. The project has been a successful collaboration between SEARHC and the department in expanding access to dental services for children enrolled in Medicaid.

A second project was implemented with an Anchorage private pediatric dentist in April 2001 to provide Medicaid pediatric dental services in the Kenai Peninsula region of the state – another region with

longstanding limitations on Medicaid dental access. This Medicaid contract has continued through SFY 2012 and has reduced the need for transportation, often air transportation, for children and their parent/caregiver to Anchorage to obtain dental services. Between SFY 2007-SFY 2011 the pediatric Medicaid dental visits under this contract averaged 1,080 visits per year. Air fare from communities in this region to Anchorage would be in excess of $500/child (assuming transportation for the child and accompanying adult.) http://www.astdd.org/state-activities-descriptive-summaries/?id=3

Iowa - I-Smile™ Dental Home Project

The I-Smile™ Dental Home Program is an initiative to ensure at-risk children have early and regular dental care. It was created in response to state legislation requiring Medicaid-enrolled (ME) children age 12 years and younger to have a dental home. In Iowa, the dental home is a network providing comprehensive care using a multi-disciplinary approach to help children achieve optimal oral health. The Iowa Department of Public Health (IDPH), Bureau of Oral and Health Delivery Systems, coordinates I-Smile™ through an agreement with the Iowa Department of Human Services (IDHS).

DPH contracts with 22 private non-profit and public agencies in Iowa to implement the Title V child health program, ensuring health services for low-income children. The I-Smile™ program is incorporated within this state Title V system. Twenty-four dental hygienists, hired by the local Title V child health agencies, work as regional I-Smile™ coordinators. The coordinators are liaisons between community organizations, families, health care providers, and dentists to establish dental homes for at-risk children.

The coordinators build local infrastructure through developing partnerships, assessing local need, program planning, training of non-dental health care providers, and promoting oral health. They also ensure care coordination services for families and provision of gap-filling services for children (e.g. screenings, risk assessment, fluoride varnish provided by dental hygienists and nurses) in public health settings. In addition to services provided by Title V child health agency staff, some pediatric and family practice medical providers also offer screenings and fluoride varnish applications to ME children younger than age 3. Through referrals, dentists provide diagnosis and treatment as needed.

The I-Smile™ annual budget (~$2.3 million/year) covers contracts with local Title V child health agencies to implement the program and also administrative costs for the Oral Health Center within the Bureau of Oral and Health Delivery Systems. IDPH builds infrastructure at the state level with activities such as promoting I-Smile™ through conference presentations and displays, creating and enhancing public-private partnerships, implementing health promotion initiatives, improving the state's child health database, and developing oral health policies. IDPH staff holds quarterly trainings for I-Smile™ Coordinators and provides contract management and technical assistance to each local agency.

The I-Smile™ multi-disciplinary network of care and, in particular, its dedicated oral health staff within the state's Title V system, is improving children's ability to access dental care. Since I-Smile™ began, 65 percent more ME children age 5 and younger have received dental services. Fifty-five percent more ME children ages 0-12 receive care from dentists. http://www.astdd.org/state-activities-descriptive-summaries/?id=214

Iowa - EPSDT Exception to Policy

Iowa is largely rural, and many counties have a limited number of dentists. During the past several years, 65-75 percent of the state's 99 counties have qualified as dental Health Professional Shortage Areas (HPSA) based on geographic, Medicaid-enrolled, and low-income population to dentist ratios. In 1997, because of a significant dental access problem and the need to make preventive oral health care more available to low-income families, the Iowa Department of Public Health (IDPH) partnered with the Iowa

Department of Human Services (IDHS) to implement the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exception to Policy program.

IDPH contracts with regional public and private non-profit agencies to provide Title V Maternal and Child Health (MCH) health services. The EPSDT Exception to Policy allowed regional Title V Child Health contractors to request reimbursement for oral screenings and fluoride varnish applications provided by dental hygienists to Medicaid-enrolled children. These services were provided in settings such as public health clinics, WIC clinics, preschools, day care facilities, schools, and Head Start centers. Regional Title V Child Health contractors were required to illustrate need by identifying the number of dentists in each county who would/would not take low-income clients and the age of the clients able/unable to be seen in dental practices. The Exception to Policy also eventually extended to Title V Maternal Health contractors for Medicaid-enrolled pregnant women. Reimbursement for services was based on agency cost to provide the service (not to exceed Medicaid-allowable rates).

In 2001, one-third of Iowa counties were reimbursed for dental services through the EPSDT Exception to Policy. That year, 860 fluoride varnish applications were billed to Medicaid by Title V contractors, one and a half times the number from the prior year and growing to nearly 3,600 in 2002. Because of the success of the EPSDT Exception to Policy in helping low-income children access preventive care, IDHS made the oral health services an EPSDT standard of care in March 2002 – contractors no longer needed to request an Exception to Policy to be reimbursed for the direct dental services provided by dental hygienists. In November 2004, the same standard of care was applied to Title V Maternal Health programs.

Iowa's standard Medicaid policy now allows Title V Maternal and Child Health contractors to bill Medicaid for oral screenings, fluoride varnish applications, sealant applications, prophylaxes, radiographs, and counseling services provided by a dental hygienist. In addition, as part of the current I-Smile™ dental home initiative, registered nurses are trained by I-Smile™ Coordinators and can then provide billable oral health screenings, fluoride varnish applications, and counseling services. The Title V contractors are no longer required to demonstrate proof of an access problem, reducing paperwork related to billing for the services.

All Iowa counties have had increases in EPSDT dental services for children as a result of improved participation by dentists as well as the services within Title V Child Health settings. http://www.astdd.org/state-activities-descriptive-summaries/?id=38

Maryland - Maryland Dent-Care Loan Assistance Repayment Program
During the 2000 Maryland legislative session, House Bill 543/Senate Bill 519 was passed providing State funding for a loan repayment program for dentists, known as the *Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP*). The purpose of MDC-LARP is to increase access to oral health care services for Maryland Medical Assistance Program (MMAP) recipients by increasing the number of dentists who treat this population. MMAP is the State Medicaid program. The Maryland Department of Health and Mental Hygiene Office of Oral Health, in partnership with the Maryland Higher Education Commission, is charged with the responsibility of implementing and monitoring this program. Dentists who participate in this program agree to provide oral health care services to a minimum of 30% MMAP recipients as a proportion of their total patient population, document this information, and submit written reports. http://www.astdd.org/state-activities-descriptive-summaries/?id=44

Maryland - Senate Bill SB 590: Legislation for the Medicaid Program and Office of Oral Health
During the 1998 session of the Maryland General Assembly, Senate Bill (SB) 590 was passed to address the many oral health issues affecting children eligible for HealthChoice (Maryland's managed care

Medicaid Program) and the Maryland Children's Health Insurance Program (MCHIP). The legislation was the result of advocacy and promotion of oral health policy by a dedicated partnership of State oral health entities committed to improving oral health access for Medicaid-eligible patients. SB 590 mandated:

- An increase in utilization of public dental services by placing under statutory authority oral health services utilization targets from 14% (in 1999) to 70% (2004) over a five-year period. As of 2010, the utilization rate has climbed to 63%. The 70% target is still in place and the data shows that utilization has continued to increase.
- Oral health services for pregnant women, a newly mandated benefit.
- Assessing the availability and accessibility of participating dentists throughout the State participating in HealthChoice/MCHIP and Medicaid Fee-for-Service and develop and implement strategies for increasing participation of dentists in these programs. SB 590 provided the foundation to establish the Dental Action Committee (DAC) in 2007 which provided seven recommendations including moving to a single statewide provider, increasing Medicaid dental reimbursement, and establishing a public health level dental hygienist. As a result of these successful efforts, the number of dentists in Maryland has increased by 400 in the past year, and that increase appears to be continuing, thus expanding availability and accessibility in Maryland.
- The establishment of an Office of Oral Health and requested that this Office to develop demonstration projects to increase access to and utilization of oral health services by underserved Medicaid beneficiaries. The Office of Oral Health at the Department of Health and Mental Hygiene has grown substantially in the past decade, now running several programs designed to support preventive services and increase access to care across the state. Two case management demonstration pilot programs were launched in Prince George's County and on the Eastern Shore. The program on the Eastern Shore continues to thrive and the option of applying for funding to hire two more case managers is currently being explored.
- Required that a statewide oral health needs assessment of Maryland schoolchildren be performed to assess oral health status and related issues such as access to preventive modalities and treatment services for children. The Survey of the Oral Health Status of Maryland School Children was conducted in 2005-2006, serving as a follow-up to surveys from prior years, a benchmark reference to assess OOH program progress, and a basis for an ongoing temporal oral health surveillance system. The 2011-2012 survey was completed in June 2012 and findings are anticipated to be available in June 2013.

In tandem with these activities, both the Medicaid dental program and the Office of Oral Health received substantially increased funding through SB 590. These were the first increases to the Medicaid dental program and the Office of Oral Health in many years. Access to oral health services for Medicaid-eligible children has continued to increase moderately and the funds for the Office of Oral Health have led to statewide education and preventive programs, a significant number of preventive oral health grant programs for local and community programs, and seven community water fluoridation start-ups.. http://www.astdd.org/state-activities-descriptive-summaries/?id=47

Maryland - St. Mary's County Pilot Dental Program

The St. Mary's County Dental Program began in June 2000 as a result of a unique partnership fashioned between the St. Mary's County Local Health Department and the Maryland Office of Oral Health with two Medicaid managed care organizations (MCOs) and the Patuxent Dental Society, a component society of the Maryland State Dental Association. Prior to the partnership and the program, only 2% of dentists (1 of 44 dentists) in St. Mary's County participated in the Maryland Medicaid Program (MMP) (statewide average – 18% in 2000) resulting in poor utilization of dental services for Medicaid-eligible

residents. Through the efforts of the partnership, and under the leadership of the St. Mary's County Health Officer, the development and consensus for the pilot project plan was finalized in April 2000. The purpose of the pilot program was to increase the number of practicing dentists in St. Mary's County who participated in the MMP with the assumption being that increased provider participation would result in increased access to dental care.

The pilot was successful and has continued to be supported through the St. Mary's Health Department. Originally, there were 5 key components to the program, each addressing providers' previous major objections to participation with the program: (1) higher reimbursement levels; (2) reduced administrative burden on participating dentists; (3) facilitation of credentialing and contracting process with MMP managed care organizations; (4) elimination of pre-authorizations for all dental procedures except orthodontic and hospital-based services; and (5) program administration by St. Mary's Local Health Department to address negative history with MMP and historical high no-show rate of patients. Today, fiscal resources for the program include grant funds from the Office of Oral Health and a local Rotary Club, which total approximately $30,000. A significant change in the past several years has been the carve-out of dental services from the overall Medicaid program (Health Choice) to a single dental program, now renamed the Maryland Healthy Smiles Program.

As of April 2013, the program continues to be supported through the St. Mary's County Health Department. There are currently 14 participating dentists (or 32% of St. Mary's County dentists), many of whom have participated since 2000. Of these, three are pediatric dental providers, one is an orthodontist, and the remaining are general family dentists. All three pediatric dental practices in St. Mary's County participate in the Healthy Smiles Program. The participating dental providers no longer have an enhanced reimbursement schedule (MCOs had originally contributed to the successful pilot of the program by agreeing to raise their dental benefit fee schedule to 72.5% of area dental fees) and now accept the current fees and pre-authorization requirements as the rest of the state of Maryland. However, reimbursement fees for many Medicaid dental service procedures increased to the American Dental Association 50th percentile as a result of state dental reform measures. The St. Mary's County Health Department provides transportation to any clients in need. The compliance rate for patients keeping appointments for their dental care remains high, although the actual percentage rate is not currently available. The participating dentists also contract independently with the St. Mary's County Health Department to provide emergency dental care/pain relief to uninsured individuals referred by the local health department. They agree to accept the same reimbursement rates as the MA fee schedule and the patient is requested to pay $50. http://www.astdd.org/state-activities-descriptive-summaries/?id=48

Massachusetts - Department of Public Health SEAL Program

The Massachusetts Department of Public Health (MDPH) developed the MDPH-SEAL (Seal, Educate, Advocate for Learning) Program, a school-based oral health prevention program to serve MassHealth eligible and other high-risk school-age children and youth. The goal of the SEAL Program is to improve children's oral health by increasing their access to preventive dental services (dental sealants and topical fluoride), and reduce oral health disparities.

The dental professionals supporting the MDPH-SEAL Program consist of registered dental hygienists (3.2FTE), two oral health prevention specialists (1.6FTE), and one licensed dentist (0.2FTE), who is also Director of one of the state's public health hospital dental programs. The staff dentist provides general supervision for the program's dental hygienists through a standing order allowing the hygienists to place dental sealants without first having a dental examination. The dental hygienists work closely with school nurses and nurse practitioners in the school-based health centers to coordinate the MDPH-SEAL Program and to implement a case management program for dental referrals.

The program serves high-risk children and those enrolled in the MassHealth (Medicaid/SCHIP) Program. MDPH-SEAL targets schools with (1) schools with at least fifty-percent free and reduced school lunch participation: (2) schools in communities with more than 15,000 MassHealth eligible children; (3) schools with school-based health centers; and (4) schools located in dental health professional shortage areas. While the program targets children in grades 2, 6, 7 and 9, it is open to any child within a participating school with permission to participate. In school-year 2011-2012, the Program serves school-age children and youth in 130 schools in 12 different Massachusetts communities.

Dental hygienists provide screenings, administer dental sealants and fluoride varnish, and provide referrals for restorative treatment and other dental needs, and follow-up as needed with both school nurses and parents. All dental services are delivered with portable dental equipment and all children may participate regardless of their insurance status or the family's ability to pay. Since its inception in 2006, the program was supported with competitive HRSA funding and some state dollars. In school year 2011-2012, the Department of Public Health Office of Oral Health became a MassHealth dental provider, allowing the Program to receive direct reimbursement from this pubic insurance program ensuring its sustainability.

The Program collaborates with the state's public health hospital dental programs, community health center dental programs, and private dental providers to ensure resources for restorative treatment and other dental care are available.

MDPH-SEAL also uses the CDC's Sealant Efficiency Assessment for Locals and States (SEALS) benchmarking tool to demonstrate the cost-effectiveness of the prevention services delivered through the Program, as well as sealant retention rates and access to restorative treatment.

The MDPH-SEAL Program has increased the number and/or level of:

- High-risk children having access to dental prevention services;
- Care coordination for children identified with untreated tooth decay;
- Awareness and knowledge of oral health by students, parents, teachers and school administration;
- Integration of oral health in general health and wellness activities in schools;
- Collaborations to support and expand oral health prevention programs;
- Oral health programs in school-based health center schools.

http://www.astdd.org/state-activities-descriptive-summaries/?id=52

Michigan – Healthy Kids Dental

The Healthy Kids Dental program was initiated in Michigan to create access to oral health care for Medicaid beneficiaries by using Delta Dental's network of participating providers. This is a demonstration program contracted by the Department of Community Health with Delta Dental Plan of Michigan to administer the Medicaid dental benefit to all Medicaid beneficiaries under age 21 residing in selected counties. Healthy Kids Dental aims to address - and ameliorate - two commonly cited reasons for dentists' non-participation in Medicaid: low reimbursement rates and administrative burden. Healthy Kids Dental reimbursement levels are identical to Delta's commercial dental plans. Administrative processes for Healthy Kids Dental - including verification of enrollment - are handled through Delta in the same manner as with commercial Delta plans. The project was initiated on May 1, 2000 in 22 counties. On October 1, 2000, the project was expanded to include an additional 15 counties. Currently the project is in 37 of Michigan's 83 counties. Healthy Kids Dental participants can receive care anywhere in the state: eligibility is based on the children's county of residence, not the location of the dentist. The number of Medicaid-enrolled children (aged 0-20) in the 37 counties totaled approximately

100,000. A 12-month assessment of the program demonstrated that through the contract: (1) substantially more Medicaid beneficiaries are receiving dental care under the Healthy Kids Dental compared to the traditional Fee-For-Service Medicaid coverage; (2) more dentists are providing care to Medicaid beneficiaries under Healthy Kids Dental compared to the traditional Fee-for-Service Medicaid program; (3) more Medicaid beneficiaries are receiving care within their county of residence rather than traveling long distances to receive care; and (4) more Medicaid beneficiaries are receiving restorative dental treatment compared to the traditional Fee-for-Service Medicaid program. http://www.astdd.org/state-activities-descriptive-summaries/?id=53

Summary

State Oral Health Programs and State Medicaid-CHIP Oral Health Programs have many opportunities for collaboration and doing so can enhance each program's ability to improve the oral health of the populations they serve. The creative and varied examples described in this document, began with collaborative conversations. The 1assessment tool can be used to facilitate and guide conversations between State Oral Health Programs and State Medicaid-CHIP Oral Health Programs in a purposeful and constructive way.

References

1. US Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.
2. Association of State and Territorial Dental Directors. Strategies to improve collaborations between state oral health programs and health center oral health programs. Retrieved June 16, 2011 from http://www.astdd.org/docs/NNOHA_ASTDD_Issue_Brief_02_11_rev.pdf.
3. Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. http://www.qualitymeasures.ahrq.gov/browse/by-domain.aspx

Endnote: In general, throughout the paper, the term "state" and "states" also refers to US territories and jurisdictions.

Key Resources

- **Association of State and Territorial Dental Directors** website: http://www.astdd.org
- **Medicaid – CHIP State Dental Association** website: http://www.medicaiddental.org