Transforming Oral Health for Families (TOHF)

Networks for Oral Health Integration within the Maternal and Child Health Safety Net

Oral Health Services Environmental Scan

New York, Maryland, Virginia, and the District of Columbia

2020

Prepared in collaboration with:

Executive Summary

Oral health is an essential component of overall health and well-being at every stage of life, particularly during early childhood, where many health-related habits are established. However, due to access gaps nearly one in four US children 2-5 years of age experience dental caries on their primary teeth, and dental caries remains predominantly prevalent among children living with limited family resources. The goal of the TOHF project is to improve the oral health of children 0 – 40 months through the integration of preventive oral health services into primary care settings in community health centers in Virginia, New York, Maryland, and the District of Columbia. The purpose of this environmental scan was to identify policy and regulatory factors at the state level that could impact this type of integration.

Key Findings

- Limited scope of practice for non-dentist and non-physician clinical providers may be hindering expansion of preventive oral health services in the primary care setting particularly for New York, Maryland, and the District of Columbia.
- Non-clinical service providers, such as Community Health Workers and Community Dental Health Coordinators in all four TOHF states are not reimbursed for preventive oral health services, including oral health assessment, oral health education, and fluoride varnish application.
- Referral services are not reimbursed on either the medical or dental side for oral health services.
- Currently no health reform initiatives, such as value-based care or pay for performance, are being utilized for oral health in any of the TOHF project states.
- Dental hygienists in the Virginia, New York, and Maryland have some additional capabilities to provide services when practicing in public health settings. Dental therapists are currently not recognized nor licensed provider types in Virginia, New York, Maryland, or the District of Columbia.
- Tele-dentistry scope and utilization has expanded in recent months in all states due to limited on site dental care available during the COVID-19 pandemic.

Future Strategies

- Work with partnering health centers to modify existing protocols to ensure that each provider type is operating at the top of the scope of practice.
- Explore supervision options and delegation opportunities to ensure care at each site is being delivered in the most cost-effective manner.
- Partner with state agencies to support and advocate for expansion of Medicaid benefits, including for alternative provider types and services such as referrals.
- Identify mechanisms to incentivize dental participation in Medicaid, considering pay for performance and value-based care modalities.
- Leverage data on successful programs using alternative provider types and expanded provider functions in different states to advocate for new scopes of practice.
- Sustain and grow capabilities to improve efficiency of care for families, including tele-dentistry and electronic health record integration.

Introduction

Oral health is an essential component of overall health and well-being at every stage of life, particularly during early childhood, when many health-related habits are established. Although well-child visits during the first thousand days of life are critical opportunities to ensure healthy development, preventive oral health services (such as age-one oral health screenings, topical fluoride therapy, and anticipatory guidance) are not routinely accessed by infants and toddlers. As a result, nearly one in four US children 2-5 years of age experience dental caries on their primary teeth, and dental caries is predominantly prevalent among children living with limited family resources.

Community health centers (CHCs) are the safety-net providers representing the largest source of comprehensive primary health care for underserved and disadvantaged communities and populations. These CHCs play a critical role in primary oral health interventions and reducing disparities in oral health care access and outcomes. Even in CHCs with co-located dental and primary care clinics, oral health services are relatively isolated from primary care. Furthermore, few CHCs are equipped with sufficient workforce to effectively address both the oral health care needs of infants and toddlers and the social determinants affecting their oral health within their families.

The purpose of this environmental scan survey is to gain knowledge regarding state-level factors impacting the integration of preventive oral health services into primary care settings in community health centers in Virginia, New York, Maryland, and the District of Columbia. The information collected from this survey will be utilized to inform the work of the Network for Oral Health Integration (NOHI) Transforming Oral Health for Families (TOHF) project, whose goal is to improve the oral health of children ages 0 – 40 months. This environmental scan will be conducted annually from 2020 to 2024.

The TOHF Project Director will work closely with State Jurisdiction Coordinators to identify options and strategies to: 1) Address access to and delivery of integrated preventive oral health services at the state/jurisdiction level; 2) Provide guidance to the Partner Health Centers (PHCs) on reimbursement systems and regulatory restrictions; and 3) Assist PHCs with modifying project strategies to ensure responsiveness to the state and local healthcare environment.

Methods

Searches related to policy and regulation for the below topic areas were conducted for the states of Virginia, New York, Maryland, and the District of Columbia and data entered into SurveyMonkey for review and analysis. Scans were conducted utilizing original available data and resources such as health professional practice acts, Medicaid information for medical and dental professionals, and state health care reform/payment innovation programs. Certain information was acquired through direct contact with state Medicaid offices, state public health departments, state licensing boards, and state medical and dental associations.

(Scope of Practice and Medicaid Fee-for-Service Reimbursement; Reimbursement for Non-Dental Clinical Providers; Reimbursement for Non-Dental Support Service Providers; Reimbursement for Dental Support Service Providers; Oral Health Referrals; Medicaid in Federally Qualified Health Centers; Health Care Reform/Payment Innovations; Dental Hygienists; Dental Therapists; Dentists Participating in Medicaid; Tele-dentistry; Additional Oral Health Information)

Results

Scope of Practice and Medicaid Fee-for-Service Reimbursement

For each state, the ability to perform the preventive oral health services of oral health screenings/risk assessments and fluoride varnish application under scope of practice was examined for numerous dental and medical provider types as well as non-clinical providers (Table 1). In all states in the TOHF project, dentists and physicians are allowed to perform both procedures, although the ability for other clinical providers varies from state to state. In Virginia, multiple clinical provider types working in a pediatric or primary care office, including medical assistants, are able to apply fluoride varnish and receive reimbursement under the state's Medicaid program. In New York, in addition to dentists and dental hygienists, physicians and nurse practitioners can provide and be reimbursed for essential oral health services while other non-dental providers can provide some of these services but cannot be reimbursed. Maryland is more limited and does not allow non-physician or non-dentist providers to deliver these services, while the District of Columbia allows nurse practitioners and physician assistants to perform these treatments. A summary of state Medicaid programs is located in Appendix A.

Table 1: Preventive oral health services procedures allowed by scope of practice for each state

Provider Type	OH Screening/Risk Assessment				Fluoride Varnish			
	VA	NY	MD	DC	VA	NY	MD	DC
MD/DO (Physician)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
NP (Nurse Practitioner)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
PA (Physician Assistant)	Yes	Yes	No	Yes	Yes	Yes	Delegation only	Yes
Pharmacists	No	No	No	No	No	No	No	No
RN or LPN (Registered Nurse) (Licensed Practical Nurses)	Yes	Yes	No	No	Yes	Delegation only	Delegation only	Delegation only
Midwives	No	Yes	No	No	No	No	Yes	No
CMA/RMA (Medical Assistant)	Yes	No	No	No	Yes	No	Delegation only	Delegation only
CHW (Community Health Worker)	No	No	No	No	No	No	No	No
DDS/DMD (Dentists)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
DT (Dental Therapists)	No	No	No	No	No	No	No	No
RDH (Registered Dental Hygienists)	Yes	Yes	Delegation only	Yes	Yes	Yes	Delegation only	Yes
"Advanced" RDH (Registered Dental Hygienists)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CDA/RDA (Dental Assistant)	Yes	No	Delegation only	No	Yes	No	Delegation only	Delegation only
CDHC (Community Dental Health Coordinators)	Yes	No	No	No	Yes	No	No	No

Reimbursement for Non-Dental Clinical Providers

Medicaid reimbursement for oral health preventive services delivered by non-dental clinical providers was evaluated for each state (Table 2). In Virginia, while many non-dental clinical provider types are allowed to complete oral health screenings, oral health education, and apply fluoride varnish, Medicaid only reimburses for fluoride varnish application. Non-dental clinical providers can be reimbursed up to six times for fluoride varnish application up until the child's third birthday, and while a risk assessment is not reimbursed or required for fluoride application and reimbursement, it is recommended by the American Academy of Pediatrics. In New York oral health screening, risk assessments, and oral health education are conducted by physicians and nurse practitioners as part of the oral health visit for fluoride varnish and are not reimbursed separately. Non-dental clinical providers may be reimbursed for a maximum of four annual fluoride varnish applications for children from birth until seven years of age. In Maryland, the only non-dental clinical providers that can be reimbursed are pediatricians and pediatric nurse practitioners who have completed a training course, while in the District of Columbia, information on reimbursement was not currently available. In Virginia, New York, and the District of Columbia, non-dental clinical providers are not required to utilize a specific oral health risk assessment tool in order receive reimbursement. In Maryland, providers must use the screening tool provided in the Maryland Fluoride Varnish and Oral Health Screening Program Manual. No state requires a specific curriculum for oral health education.

Table 2: Medicaid Reimbursement for Non-Dental Clinical Providers

Reimbursement Type	VA	NY	MD	DC
Oral health screening/risk assessment (children under 6)	No	No	Part of EPSDT Encounter Rate	Yes
Oral health instruction and education (children under 6)	No	No	No	No
Fluoride varnish application (children under 6)	Yes	Yes	Part of EPSDT Encounter Rate	Yes
Oral health preventive services (children 6 - 12)	Yes (Fluoride)	No	Unknown	Unknown

In several states where non-dental clinical providers are reimbursed for oral health preventive services, whether individually or part of an encounter rate, they are able to delegate the delivery of the services to non-billing team members and still be reimbursed (Table 3).

Table 3: Medicaid Reimbursement with delegation of services by non-dental clinical providers to non-billing providers

Service Type	VA	NY	MD	DC
Oral health screening/risk assessment	Yes	Yes	Yes	Yes
Oral health instruction and education	May Delegate Not Reimbursed	May Delegate Not Reimbursed	May Delegate Not Reimbursed	No
Fluoride varnish application	Yes	Yes	Yes	Yes

Reimbursement for Non-Dental Support Service Providers

In all four states of the TOHF project, non-dental support service providers, such as Community Health Workers, provide preventive education related to an array of health conditions and links to resources to supplement the efforts of non-dental clinical providers. In Virginia and the District of Columbia, Community Health Workers must be certified, while in New York and Maryland there is no required state certification. In Virginia, non-dental support service providers cannot be reimbursed by Medicaid for oral health education, although it is part of their training curriculum, and may not apply fluoride varnish. In New York and the District of Columbia, these workers are also not eligible for reimbursement for oral health services. In Maryland, non-dental services providers may only bill for oral health evaluation and fluoride varnish application for children under three years of age and caregiver oral health education when the services are performed under the regulations of the EPSDT guidelines, and oral health is not part of the curriculum for Community Health Workers.

Reimbursement for Dental Support Service Providers

In all four states of the TOHF project, dental support service providers referred to as Community Dental Health Coordinators are present. In Virginia and New York, these provider types cannot be reimbursed for oral health education, and they cannot apply fluoride varnish. In Maryland and the District of Columbia the services of Community Dental Health Coordinators also cannot be reimbursed.

Oral Health Referrals

Reimbursement for oral health referrals was assessed in each state for different provider types (Table 4). No state in the TOHF project currently provides reimbursement for making a referral to a dental provider, and no state provides reimbursement to either dental or medical providers for ensuring the loop in closed on the referral.

Table 4: Reimbursement for oral health referral by provider type by state

Provider	VA	NY	MD	DC
Non-Dental Clinical Provider Reimbursed for Making a Referral to Dental Provider	No	No	No	No
Non-Dental Clinical Provider Reimbursed for Completing a Referral to Dental Provider	No	No	No	No
Dental Provider Reimbursed for Completing a Referral from Non-Dental Clinical Provider	No	No	No	No

Medicaid in Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are care clinics that qualify for specific reimbursement systems under Medicare and Medicaid and receive federal Health Center Program grant money intended to finance care for uninsured populations. These centers are an important component of the oral health safety-net, and therefore reimbursement can significantly impact the access to care. Medicaid reimbursement policies for preventive oral

health services were examined for each state (Table 5). In Virginia, Medicaid insurance is a carve out for both medical and dental plans and DentaQuest is the Medicaid dental insurer. In New York, reimbursement is not carved out of the prospective payment system encounter rate, but FQHCs can be reimbursement for medical and dental services provided on the same day, which is also true for Maryland and the District of Columbia. In Maryland, oral health screening, risk assessment, and fluoride varnish application are included in the billing rate for EPSDT visits.

Table 5: Medicaid Reimbursement Policies for FQHCs for each state

Medicaid FQHC Reimbursement Policy	VA	NY	MD	DC
Non-dental clinical providers or team required to take a training course (for example, oral hygiene instruction, fluoride varnish application)	No	No	Yes	Yes
FQHCs can be reimbursed for medical and dental services provided on the same day	Yes	Yes	Yes	Yes
Reimbursements for preventive oral health services by non-dental clinical providers is carved out of the federally qualified health center (FQHC) prospective payment system encounter rate	No	No	No	No

Medicaid Coverage for Prenatal Oral Health Care

The oral health status of a pregnant woman can ultimately impact the oral health of her child. Dental coverage for pregnant women has both the potential to reduce the likelihood of a woman transmitting caries causing bacteria to her baby, as well as provide an opportunity for education related to infant and toddler oral health care. All four states participating in the TOHF program provide a Medicaid dental benefit for pregnant women. In Virginia, as well as the District of Columbia, Medicaid provides a comprehensive dental benefit for enrolled pregnant women which lasts until 60 days postpartum through the last day of that month. In New York, prenatal care providers are required to assess need for dental care at the first prenatal visit and refer to a dentist as needed, where coverage is the same as it is for all adults. In Maryland, despite dental coverage, there is concern that pregnant women are not taking advantage of the Medicaid dental benefit they receive and could benefit from medical and dental providers being incentivized for completed referrals.

Health Care Reform/Payment Innovations

Related to reimbursement, Virginia does not currently have a value-based care or pay-for-performance program for oral health, however, it is an up and coming topic area where work is being focused. Similarly, no programs for oral health are present in New York, Maryland, or the District of Columbia.

Dental Hygienists

As some states in the nation have investigated embedding dental hygienists into primary care settings, the scope and supervision levels for hygienists in the four TOHF states were examined. In Virginia, New York, and the District of Columbia, there were no separate distinctions of dental hygienists. However, in Virginia, scope of practice depends on where the registered dental hygienist practices. Those working for a safety-net clinic and performing remote supervision services can provide more services under direct access and general supervision if they are providing care in schools, nursing homes, low-income housing, and mobile care vans compared to those working in a private practice setting. In New York, dental hygienists practice under both general and personal supervision, and may practice under a collaborative arrangement with a dentist, but only in an Article 28 facility where the dentist has a formal arrangement with the facility. Maryland has a separate designation of Public Health Dental Hygienist, that requires both classroom and supervised practice in a public health dental clinic or FQHC. In the District of Columbia there are no additional allowances for differing practice locales.

Dental Therapists

Dental therapists are currently not recognized nor licensed provider types in Virginia, New York, Maryland, or the District of Columbia. There are states in the United States that do recognize this provider type or are in the process of developing licensure regulations, scope of practice, and educational and credentialing requirements.

Dentists Participating in Medicaid

Particularly important to the referral component of preventive oral health services integration is the availability of dentists that participate in Medicaid. As in many states across the country, finding accurate and up to date information on the number of active Medicaid providers as well as those accepting new patients in the TOHF states proved to be a challenge. Many providers anecdotally indicate that reimbursement rates and the administrative efforts necessary to submit claims make participation prohibitive.

Tele-dentistry

As technology expands and the healthcare environment changes, the role of tele-dentistry has moved to the forefront. In Virginia, due to the COVID-19 pandemic, technology and HIPAA-based restrictions were eased to allow providers to begin using tele-dentistry. Prior to this many providers were not utilizing this approach to care, however, since the regulations were adjusted there has been an increase in safety net clinics utilizing tele-dentistry. Dental providers report it to be useful for screening, triage and patient education but that it is not a substitute for dental treatment. New York has allowed billing for tele-dentistry services since 2018, and during the COVID pandemic, has greatly expanded the use of telehealth services and allowed billing for telephonic dentistry. In Maryland, tele-dentistry for problem-focused evaluation became Medicaid reimbursable in response to Covid-19 related limitations to in-person dental services. In 2020 the District of Columbia allowed enrolled dental providers to provide and submit claims for oral health assessments, triage, and dissemination of oral health education to Medicaid beneficiaries at remote locations.

Additional Oral Health Information

Other pertinent information related to oral health include fluoride access and dental public health infrastructure. Virginia has a high fluoridation rate (96%), however, access to clean, safe water is not equitable. In Maryland the fluoridation rate is 93.7%, while New York has a fluoridation rate of approximately 71%, however when New York City is removed from the data, only about 50% of the remaining state population has access to fluoridated water. In Maryland, Public Health dental hygienists often serve in administrative roles within state and county health departments, and Maryland has three Regional Oral Health Coordinators who are certified Public Health Dental Hygienists.

Discussion

Each state in the TOHF project has variations in scope of practice, reimbursement allowances, and utilization of certain provider types for oral health services. However, these differences may identify promising practices that can be implemented in one or more locations utilizing policy, advocacy, and support of best practices. Analysis of different barriers to care, facilitators to care, and recommendations for policy can allow the TOHF project to focus resources on priority strategies for both short- and long-term results.

Barriers to Care

Many factors influence a person's ability to access dental care. For most individuals or families, there is not simply one obstacle to overcome, but rather a multifaceted and complex situation. Barriers to obtaining oral health services include both actual and perceived impediments. Addressing the root causes that prevent access such as patient and provider knowledge, insurance coverage, and clinical care integration may significantly reduce barriers to care. Families may not be able to access oral health services because they are unavailable, inaccessible, or in some areas, lack sufficient providers, particularly Medicaid providers, to meet the needs of the population. Other factors such as limited transportation, inadequate office hours and few options for non-English speaking patients add to the difficulty in receiving care. Out-of-pocket payments for non-Medicaid dental care coverage remain high, which may keep other families from affording care. Challenges may exist because families don't know how to find services or hold the misconception that oral health isn't as important as other health services. For these families, lack of case coordination and low oral health literacy reduce the chance for better oral health outcomes.

In regard to children and pregnant women specifically, these groups are much more likely to access primary medical care versus dental care. Moreover, racial and socioeconomic disparities exist in oral health care as they do in general healthcare. African American third graders and those enrolled in free/reduced cost lunch programs are more likely to experience tooth decay. Furthermore, only about 44% of Medicaid-enrolled pregnant women visited the dentist when the pregnancy dental benefit was enacted in Virginia, and even fewer African American/Hispanic and low-income women visited the dentist. In Maryland, oral health care providers that accept Medicaid are unevenly distributed throughout the state and multi-lingual culturally competent practices are even more limited. There are few campaigns employing holistic, family-centered oral health care and prevention messaging. The opportunity exists to address many of these barriers through oral health integration in a primary care setting.

Opportunities to Facilitate Care

Workforce and Scope of Practice

While all states in the TOHF network have active Community Health Workers and Community Dental Health Coordinators, neither of these provider types is reimbursed for oral health services in any state. As these health workers can provide oral health education, this may be an opportunity to shift anticipatory guidance and oral health education from traditional primary care settings to non-clinical settings, thus improving oral health literacy and oral health outcomes. If these services were reimbursed, it would provide an incentive to enhance oral health services and reduce the burden on clinical care providers.

In July 2020, medical assistants in Virginia were added to the list of providers able to provide fluoride varnish. Many health centers in the state indicated that medical assistants would be key to increasing fluoride varnish application due to the high amount of face time they have with the patients and a lower hourly rate compared to a nurse, nurse practitioner, physician assistant, or physician, driving the policy change. By assisting health centers in Virginia with incorporating the medical assistant into the oral health preventive services workflow, and showing positive outcomes, the TOHF project may be instrumental in advocating in other states to expand the scope of practice for additional provider types in order to increase access to care.

Dental hygienists in Virginia, New York, and Maryland have some additional capabilities when practicing in public health settings and may be leveraged for additional access. Although dental therapists are currently not recognized nor licensed provider types in Virginia, New York, Maryland, or the District of Columbia, advocacy for this role and supportive evidence from other state's implementation may be an opportunity to increase access.

Oral Health Education and Care Coordination

Improving oral health outcomes for children and families requires multiple strategies over a number of systems. Efforts must be directed to increase patient and provider knowledge regarding oral health and overall health, secure payment models for oral health services, and facilitate clinical care coordination to expand access to dental care. Additionally, oral health education should take into account cultural differences and attitudes about oral health among patients served and should draw connections between oral disease and other adverse health conditions whenever possible to demonstrate oral health's important role in wellness.

Care coordination and integration is essential to creating and maintaining a comprehensive care environment and to ensure medical and dental providers are practicing to the fullest extent of their education and training. Providers can work together to not only efficiently provide needed health services to patients, but also to address health-related social needs like food insecurity, transportation, housing, and education-based services by partnering with community organizations. Integrated oral health in primary care settings will increase opportunity for education, screening, and early referrals for needed care. Care coordination will allow families to better navigate the system

Policy

Access to affordable care is key. Virginia has a robust Medicaid dental benefit for children and pregnant women, and the legislature approved a comprehensive dental benefit for all adults in March 2020. However, shifting budgetary allotments in the midst of the COVID-19 pandemic put this benefit in jeopardy. Supporting coverage for all adults would likely increase dental visits for children because parents and caregivers that are valuing and obtaining dental care would be more likely to value this care for their children. The Maryland Medicaid program includes dental benefits for children, pregnant women, and Rare and Expensive Case Management (REM) adult populations. Dental coverage for children is not optional and is imbedded in all MCO plans. Additionally, insurers and Managed Care Organizations need to provide more transparent and understandable information to individuals related to coverage and availability of services. Up to date provider directories used in conjunction with case managers can ensure every member of the family is receiving adequate care. However, oral health coverage provided by Medicaid and through insurance is limited and does not include payment for case management, care coordination or other services that would support the connection to services. No state program is currently reimbursing for oral health referrals. Incentivizing completed referrals may increase the number of children receiving necessary dental treatment and obtaining a dental home.

Tele-dentistry also shows great promise for oral health integration, expanded access to care, and a reduction in non-trauma related oral health emergency visits. Support for continued expansion in scope of this service should be encouraged post-pandemic and evaluated to determine effectiveness and value.

Future Policy Efforts

Policy efforts related to oral health in all four TOHF states should align around the facilitators to obtaining care. Future policy should:

- Support funding for expanded Medicaid benefits
- Provide incentives for dental providers to participate in Medicaid
- Promote value-based payment and incentive programs prioritizing oral health
- Include oral health services in the scope of practice for other provider types
- Expand and support funding policies and programs focused on preventing oral disease
- Establish oral health outcome goals, metrics, and monitoring processes
- Provide reimbursement for more provider types
- Incorporate oral health education into training for additional health professions
- Integrate medical/dental and expand oral health services provided by FQHCs
- Utilize school-based oral health programs as a component of integrative care
- Establish standards for cultural competency and language access for Medicaid oral health programs and contractors

Conclusions and Recommendations

- Work with partnering health centers to modify existing protocols to ensure that each provider type is operating at the top of the scope of practice.
- Explore supervision options and delegation opportunities to ensure care at each site is being delivered in the most cost-effective manner.
- Partner with state agencies to support and advocate for expansion of Medicaid benefits, including for alternative provider types and services such as referrals.
- Identify mechanisms to incentivize dental participation in Medicaid, considering pay for performance and value-based care modalities.
- Leverage data on successful programs using alternative provider types and expanded provider functions in different states to advocate for new scopes of practice.
- Sustain and grow capabilities to improve efficiency of care for families, including tele-dentistry and electronic health record integration.

Appendix A – Medicaid Programs by State

	VA	NY	MD	DC
Administration of Medical benefit	Contracted out (Payer managed Medicaid)	Contracted out (Payer managed Medicaid)	Contracted out (Payer managed Medicaid)	In-House (State administered)
Administration of Dental benefit	Contracted out (Payer managed Medicaid)	Contracted out (Payer managed Medicaid)	Contracted out (Payer managed Medicaid)	In-House (State administered)
Marketplace Medicaid Dental coverage plan for children	All plans embedded pediatric dental coverage (no opt out)	Medical plan with optional pediatric dental coverage	All plans embedded pediatric dental coverage (no opt out)	All plans embedded pediatric dental coverage (no opt out)
Incentive programs for medical providers related to oral health	No	No	No	Do Not Know
Incentive programs for dentists to participate in Medicaid	No	No	No	Do Not Know
Medical and Dental claims reimbursed from same medical budget	Yes	Yes	No	Yes
Incentives for Dental providers related to oral health	No	No	No	Do Not Know
State Medicaid plan has ACA oral health key performance indicators	Do Not Know	Do Not Know	Do Not Know	Do Not Know
Value-based care or Pay-for-Performance for oral health	No	No	No	No
Percentage of dentists that actively participate in Medicaid	34%	Do Not Know	Do Not Know	Do Not Know

Appendix B – Glossary

Dental Support Service Providers – Examples include Community Dental Health Coordinators

EPSDT - Early and Periodic Screening, Diagnostic and Treatment is the child health component of Medicaid

Non-Dental Clinical Providers – Examples include physician, physician assistant, nurse practitioner, nurse, midwife, medical assistant

Non-Dental Support Service Providers – Examples include community health educator, promotora, health navigator, community health worker, home visitor, WIC staff

Appendix C - References

Virginia

- AAP, Bright Futures Tool: http://files.ctctcdn.com/09603ae0101/ef05164f-4137-4cf0-9de3-cfc65ed5ccc5.pdf
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- ADA: https://www.ada.org/en/public-programs/action-for-dental-health/community-dental-health-coordinators
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- ADHA, SDF info by state: https://www.adha.org/resources-docs/Silver_Diamine_Fluoride_State_by_State_Information.pdf
- Bright Futures Oral Health Pocket Guide: https://www.mchoralhealth.org/pocket/index.php
- Brooke Crouch, RDH, New Horizons Healthcare (RDH Scope of Practice)
- CDC: https://nccd.cdc.gov/DOH_MWF/Reports/Summary_Rpt.aspx
- DentaQuest, Claim Submission Requirements (Smiles for Children Manual for Providers): https://www.dentaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-Smiles-For-Children-ORM.pdf/?lang=en-US
- DentaQuest: Virginia Medicaid dental plan administrator
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- DMAS, Performance Incentive Awards Program for Non-oral Health Related Factors (ended 2019): https://www.dmas.virginia.gov/files/links/813/PIA%20Fact%20Sheet.pdf
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- Smiles for Children, Annual Dental Report the General Assembly, SFY 2019: https://rga.lis.virginia.gov/Published/2019/RD565/PDF
- Smiles for Children: Virginia's Medicaid dental benefit, includes pregnant women and emergency extraction benefit for enrolled adults
- Smiles for Life, FV Training for Medical Providers: https://www.smilesforlifeoralhealth.org/buildcontent.aspx?pagekey=101563&lastpagekey=101554&userkey=15571389&sessionkey=5761223&tut=555&customerkey=84&custsitegroupkey=0
- Smiles for Life, Learning Modules (All): https://www.smilesforlifeoralhealth.org/buildcontent.aspx?pagekey=101554&lastpagekey=62948&userkey=15578246&sessionkey=5768035&tut=555&customerkey=84&custsitegroupkey=0
- Smiles for Life, Oral Health Risk Assessment Tool: https://smilesforlifeoralhealth.org/pdf/smilesforlife/Oral_Health_Assessment_Tool.pdf
- Smiles for Life: A national, interprofessional online training program
- Tele-dentistry implementation guide: https://vahealthcatalyst.org/wp-content/uploads/2020/07/Crisis-Tele-dentistry-Implementation-Guide-DRAFT-7.21-update.pdf
- Virginia Department of Health, Practice Guidance for VA's Prenatal and Dental Providers: https://www.vdh.virginia.gov/content/uploads/sites/30/2019/03/PracticeGuideforVirginiaPrenatalDentalProvidersWEB.pdf

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- Virginia Health Catalyst, Caring for Different Population Groups/Resources: https://vahealthcatalyst.org/provider-resources/caring-for-population-groups/
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New York

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