

Improving Rural Oral Health: Six States' Response to the United States Department of Health and Human Services Oral Health Strategic Framework

Key Findings

- Several states have innovative projects for advancing oral health for rural children. Six states' experiences are explored: Colorado, Iowa, New Mexico, North Carolina, Pennsylvania, and South Carolina.
- Access to dental insurance through marketplaces varied considerably by state.
- State Offices of Rural Health can play important programmatic roles in improving oral health assess for children, either as the source of technical assistance, systems integrator, or connector of partners.

Overview

The United States Public Health Service Oral Health Coordinating Committee published the Oral Health Strategic Framework 2014-2017 for the Department of Health and Human Services (HHS).¹ The framework includes five goals for advancing oral health in America: (1) the integration of oral health into primary care; (2) oral health promotion and disease prevention; (3) improved access to care and equity; (4) improvements in oral health literacy; (5) and advancements in oral health-related public policy and research.¹ The document goes on to explore how its administrative units are making these goals actionable.

In the sections that follow, we explore how six states from different regions of the country have responded to the HHS Oral Health Strategic Framework, specifically, how they are addressing items 1 (oral health interprofessional practice) and 3 (improved access to care). It is important to note that the examples presented are not a comprehensive account of all oral health programmatic and policy investments by the select states, but highlight promising practices that could be replicated in other states to address rural oral health equity for children. We chose the following states to include in our assessment: Colorado, Iowa, New Mexico, North Carolina, Pennsylvania, and South Carolina. These states were chosen because they (a) represent each region of the country, (b) reflect different models of health care reform implementation, and (c) were identified as actual or potential implementation states for a national public-private initiative focused on improving oral health interprofessional practice in rural health clinics. Where appropriate, we also document how states are using public-private partnerships to advance rural oral health equity.

Two programs were operative in all or some of the states studied: The Health Resources and Services Administration Oral Health Service Expansion grant program (all states) and the Medical Oral Expanded Care (MORE) program of the Dentaquest Foundation (Colorado, Pennsylvania and South Carolina). In 2016, HHS' Health Resources and Services Administration awarded nearly \$156 million in funding to support 420 health centers in increasing access to integrated oral health care services and improving oral health outcomes for health center patients. Forty percent (166) of the funded health

centers are located in rural areas. These Oral Health Service Expansion (OHSE) supplemental funds are intended to increase the number of patients receiving oral health services and the number of oral health service providers at health centers. These supplements are ongoing annual awards. The MORE Care program seeks to expand the provision of primary and secondary oral health care in primary care medical offices, with a focus on rural populations. The program is implemented through collaborative efforts of State Office of Rural Health linked with rural primary care practices. Further information is available at https://www.dentaquestinstitute.org/learn/quality-improvement-initiatives/medical_oral_expanded_care.

The states studied reported promising practices for improving oral health in rural communities through a variety of approaches: expansion of oral health programs at Federally Qualified Health Centers, marketplace dental plans, interprofessional practice pilot projects, and access to care improvements. In all instances, the State Offices of Rural Health appear to play important programmatic roles either as the source of technical assistance, systems integrator, or connector of partners. As individual states and federal agencies continue to follow the HHS Oral Health Framework, it is essential to involve partners who understand the uniqueness of rural health systems as well as oral health issues.



Background: An estimated 23% of Colorado’s 2015 population of 5.5 million persons are under age 18. Statewide, 70.1% of parents reported their child’s oral health as excellent or very good; 77.6% reported that their child had received a preventive medical visit in the past year.² As reported by the American Dental Association, 53% of dentists in Colorado participated in Medicaid for child services in 2014, compared to 42% across the U.S.³

Fifteen of Colorado’s 64 counties are geographic dental health professional shortage areas.

IMPROVING ACCESS TO ORAL HEALTH CARE

Safety Net Capacity. Colorado had 20 Federally Qualified Health Centers (FQHCs) in 2015. Seventeen FQHCs provided dental services; they covered 30 counties. Sixteen of the 17 FQHC dental programs in 2015 provided a full scope of services, with the 17th FQHC using a dental hygienist to provide screenings. Ten health Centers in Colorado received HRSA Oral Health Service Expansion awards or a total 2016 award amount of more than \$3.7 million in oral health expansion funding for 10 community health centers in 2016.

Dental Insurance through the Marketplace. Colorado offers pediatric dental benefits through medical insurance plans, however participation rates are unavailable. Although stand-alone dental plans for the other states included in this brief are reported at HealthCare.gov,⁴ Colorado is not included. According to a consumer website, www.coloradohealthinsurance.com,⁵ Colorado had nine insurance companies offering stand-alone plans.

In addition to these dental insurance plans, the consumer website also promotes two discount plans, which are not insurance products but plans that offer discounts for enrollees who are likely uninsured.

| Insurance Company | Number of Plans |
|-------------------------------|-----------------|
| Humana One | 3 |
| Alpha Dental Plan | 2 |
| Delta Dental of Colorado | 1 |
| United Health One | 2 |
| National General | 1 |
| Ameritas Dental Insurance | 3 |
| Cigna | Unpublished |
| Anthem Blue Cross Blue Shield | 3 |
| Dental Plans.com | Unpublished |

*ADVANCING ORAL HEALTH
INTERPROFESSIONAL PRACTICE*

Innovations through Oral Health Interprofessional Practice. *Cavity Free at Three* is an initiative aimed at improving the delivery of oral health prevention by medical and dental providers through training and the provision of evidence-based resources and tools. A description of the project and its resources are available at <http://www.cavityfreeatthree.org/>. It was originally administered by the state’s Area Health Education Center program then was moved under the Colorado Public Health Agency. The initiative has considerable support from state government. The Governor has gone on the record stating his plan is to ensure children are covered and treated, recognizing the link between oral and physical health.

- *Cavity Free at Three* is supported through several key public-private partnerships. Financial support comes from Delta Dental of Colorado Foundation, Kaiser Permanente, Rose

Community Foundation, Caring for Colorado Foundation, and the Colorado Health Foundation.

- Colorado is an implementation state for the DentaQuest Institute's *Medical Oral Expand (MORE) Care Initiative*. This public-private partnership builds on State Office of Rural Health leadership to facilitate adoption of oral health interprofessional practice in rural health clinics. This work includes defining optimally efficient collaborative referral management relationships with community dentists. South Carolina served as the Phase 1 state. Colorado and Pennsylvania are Phase 2 implementation states with broader replication planned in partnership with other state offices of rural health.
- A recurring theme in key informant interviews was the leadership model for championing rural oral health interprofessional care that has been essential for Colorado's success. The University of Colorado has been an instrumental partner for *Cavity Free at Three*. Specifically, Mark Deutchman, MD was identified as a champion and Colorado faculty, particularly the Director of its Rural Family Medicine Residency Program, are regarded nationally as the 'creator of intelligence' around oral health interprofessional care. More information is available at <https://cohealthop.org/cavity-free-at-three-benefit/>.



Background: An estimated 23% of Iowa's 2015 population of 3.1 million persons are under age 18. Statewide, 72.2% of parents reported their child's oral health as excellent or very good; 82.1% reported that their child had received a preventive medical visit in the past year.² As reported by the American Dental Association, 86% of dentists in Iowa participated in Medicaid for child services in 2014, compared to 42% across the U.S.³ Sixty-six (66) of Iowa's 99 counties are geographic dental health professional shortage areas.

IMPROVING ACCESS TO ORAL HEALTH CARE

Safety Net Capacity. Iowa has 14 Federally Qualified Health Centers (FQHCs) with 12 providing full dental care. Iowa's geography and population distribution is such that most FQHCs are located along the state's border and serve residents of neighboring states. Approximately half the dental programs are located in small urban areas with others in more rural communities. In total, Iowa FQHCs provide care to 27 rural service areas, 9 in urban areas, and 4 from other states. Residents of Iowa's border states are reported to seek dental care in Iowa due to better availability of dental providers. Five health centers in IA received HRSA Oral Health Service Expansion awards for a total 2016 award amount of \$1.925 million.

Strengthening the state's safety net is also being accomplished through a public-private partnership with the DentaQuest Foundation. In 2015, the Iowa Primary Care Association (PCA) was awarded a third and final year of funding through the DentaQuest Foundation's Strengthening Oral Health Safety Net (SOHSN) initiative. This funding will allow the PCA to continue to support FQHC dental programs, encourage efforts to integrate care, work with other partners on oral health issues of regional and statewide impact, and facilitate the provision of training and technical assistance to FQHC dental programs.

Another example of a public-private partnership to strengthen Iowa's dental safety net is its relationship with the Delta Dental of Iowa Foundation. The Iowa PCA partnered with Delta Dental of Iowa Foundation to provide funds for two new dental directors to attend the National Oral Health Learning Institute sponsored by the National Network for Oral Health Access (NNOHA). The learning institute provided new dental directors with the opportunity to increase the leadership skills necessary for running efficient dental clinics and to advocate for oral health in their communities.

Dental Insurance through the Marketplace. In Iowa, there are medical insurance plans available through its health insurance exchange that provide dental benefits for children (see table at top of next page), although enrollment estimates are not published. Iowans also have access to ten stand-alone dental insurance plans through four insurance companies in 2015 as summarized from HealthCare.gov.⁴ All ten plans were available in each of Iowa's 99 counties covering 12.1% of children in the state.⁶ Rural-urban rates were not available.

| Insurance Company | Number of High Coverage Plans* | Number of Low Coverage Plans* |
|--|--------------------------------|-------------------------------|
| BEST Life & Health Insurance Company | 2 | 2 |
| Delta Dental of Iowa | 2 | 1 |
| Dentegra Insurance Company | 0 | 1 |
| Truassure Insurance Company | 1 | 1 |
| *High coverage plans have higher premiums with lower copayments & deductibles. Low coverage plans have lower premiums with higher copayments & deductibles | | |

Dental Care Improvement Policies. Iowa is supporting evidence-based approaches to improve access through innovative billing practices.

- *Dental Hygiene Reimbursement.* The state has collaborative agreements with dental hygienists working in local public health settings who can bill Medicaid for care they provide, thus extending the dental workforce for underserved communities.
- *Incentivized Risk Assessments.* As a part of the state’s oral health plan, dentists receive a 10% increase in their fees if they use an approved risk assessment as a part of care delivery. Participating dentists also receive a year-end bonus for their performance in risk-based care. This is financed by a Medicaid 1115 waiver. Program evaluation documents are available at <http://ppc.uiowa.edu/publications/all?f%5Bauthor%5D=971>.

ADVANCING ORAL HEALTH INTERPROFESSIONAL PRACTICE

Oral Health Interprofessional Policies. Iowa is facilitating a practice environment that supports the practice of oral health interprofessional practice in primary care and school-based settings to improve pediatric dental outcomes.

- *Innovating Reimbursement Models:* Like most states, Iowa authorizes fluoride varnish application by primary care providers in its Medicaid program. The state has had discussions on separating reimbursement of oral health preventive care from the Early, Periodic, Screening, Diagnosing, and Treating (EPSDT) encounter, which is currently bundled. As Iowa pursues privatization of Medicaid, the likelihood of a separation was unclear at the time of interviews. Medicaid Managed Care Organizations were already exploring how to collaborate with providers on oral health since they cannot pay dentists directly. Regional Accountable Care Organizations have begun developing in the state. Most have dental components.
- *Screening Requirement.* Iowa also has a statewide dental screening requirement for children entering public schools, which is conducted by school nurses who have been appropriately trained by the state health department. About 70 percent of all children provide dental screening certificates as required for entry into kindergarten or ninth grade (<https://idph.iowa.gov/ohds/oral-health-center/school-screenings>).



Background: As of 2015, estimated 1.24 million children (age less than 18 years) live in New Mexico. Nearly half (48%) of residents in New Mexico consider themselves Hispanic, while only 38% identify as white alone. Statewide, 62.6% of parents reported their child’s oral health as excellent or very good; 81.1% reported that their child had received a preventive medical visit in the past year.² As reported by the American Dental Association, 53% of dentists in New Mexico participated in Medicaid for child services in 2014, compared to 42% across the U.S.³ Fifteen (15) of New Mexico’s 33 counties are geographic dental health professional shortage areas.

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Safety Net Capacity. New Mexico has 16 Federally Qualified Health Centers (FQHCs), all providing oral health services. In 2014, they employed 71 full-time and 95 part-time dentists, as well as 49 full-time and 60 part-time dental hygienists. There are approximately 40 dental sites with 30 of them in rural areas, many of which are co-located with other FQHC services. Approximately 90% of FQHCs have at least one dental site. Four health centers in New Mexico received HRSA Oral Health Service Expansion awards for a total 2016 award amount of \$1.75 million. It was reported that these expansions would serve an additional 1,500 patients. While all health centers offer oral health services, only one-third of patients have access to oral health services at their clinical delivery site. Some access challenges were reportedly due to excessive dental provider vacancies in the FQHCs.

One of the most significant challenges in expanding the dental safety net in New Mexico is the competing demand for behavioral health services. It was reported that state funding has been historically difficult to leverage for expansion of safety net care because of fiscal constraints. The need and advocacy for behavioral health service expansion tends to overshadow oral health investments.

Dental Insurance through the Marketplace. There are no health insurance plans in New Mexico that provide dental benefits to pediatric enrollees. However, residents in all 33 counties had access to 12 stand-alone dental insurance plans through three insurance companies in 2015 as summarized from HealthCare.gov.⁴ The state had the third highest participation rate for stand-alone dental plans in the country, covering 22.0% of New Mexico’s children.⁶

| Insurance Company | Number of High Coverage Plans* | Number of Low Coverage Plans* † |
|---|--------------------------------|---------------------------------|
| BEST Life & Health Insurance Company | 2 | 2 |
| Blue Cross Blue Shield of New Mexico | 2 | 2 |
| Renaissance Life & Health Insurance Company | 2 | 2 |

*High coverage plans have higher premiums with lower copayments & deductibles. Low coverage plans have lower premiums with higher copayments & deductibles.

†An additional four urban counties had access to a low coverage plan administered by the Dentegra Insurance Company. These counties included: Bernalillo, Dona Ana, Santa Fe, and Valencia.

Potential Dental Practice Act Modifications. In addition to strengthening the dental safety net and dental insurance products, New Mexico has explored the potential impact of dental therapy models on access to dental care for its residents. This work has been carried out through a public-private partnership that includes funding from HRSA and the W.K. Kellogg Foundation. The impact of dental therapists on improved access to dental care among rural has not been measured. The model in New

Mexico was recently described in the *Journal of Dental Hygiene*, which indicated dental therapists are mostly employed in private practice settings and located in underserved communities.⁷

ADVANCING ORAL HEALTH INTERPROFESSIONAL PRACTICE

New Mexico is addressing innovations in oral health interprofessional practice through improvements in higher education curriculum and care delivery models in underserved communities.

- *Enhancements to Nurse Practitioner Training Program.* The University of New Mexico's School of Medicine received funding from HRSA to enhance its oral health education program, including the integration of oral health evaluation skills for its Advance Nurse Practitioner Program. Specifically, they will use a primary care oral health delivery model that brings together dentists, physicians, and advance practice nurses to a community health center setting to address oral health disparities.
- *Colocation and Training Model.* The University of New Mexico, along with a coalition of public private partnerships with funding from the W.K. Kellogg Foundation, developed a colocation model for oral health at a community health center in a rural setting. The model included robust training of primary care providers on what they can do within their scope of practices in the state of New Mexico to address oral health.⁸



Background: As of 2015, estimated 2.26 million children (age less than 18 years) live in North Carolina. The majority (64%) of residents in North Carolina consider themselves white alone, with 9% identifying as Hispanic and 22% identifying as Black or African American. Statewide, 74.3% of parents reported their child’s oral health as excellent or very good; 76.7% reported that their child had received a preventive dental visit in the past year.² As reported by the

American Dental Association, only 27% of dentists in North Carolina participated in Medicaid for child services in 2014, compared to 42% across the U.S.³ Thirty-two (32) of North Carolina’s 100 counties are geographic dental health professional shortage areas.

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Safety Net Capacity. As of January 2016, North Carolina had an estimated 36 public health dental clinics with mobile services across 113 access points. The Department of Public Health provides direct dental services through their public health dental clinics which employs teams of dentists, dental hygienists and/or dental assistants. Fifteen (15) health centers in NC received HRSA Oral Health Service Expansion awards for a total 2016 award amount of \$3.3 million.

Shifts in Medicaid Participation. It is estimated that North Carolina Medicaid provides dental coverage for approximately 1.1 million children. The state observed a decline in enrollment in the Children’s Health Insurance Program (CHIP) after the passage of the Affordable Care Act. An estimated 70,000 children were moved from CHIP to Medicaid. Historical CHIP enrollment ran as high as 250,000 and is now around 100,000.

Dental Insurance through the Marketplace. There are some medical insurance plans that provide for pediatric dental coverage, although market penetration estimates are unpublished. North Carolinians in all 100 counties had access to ten stand-alone dental insurance plans through three insurance companies in 2015 as summarized from HealthCare.gov.⁴ The state had the fourth lowest rate (3.6%) of children participating in stand-alone dental plans in the U.S.⁶

| Insurance Company (counties served) | Number of High Coverage Plans* | Number of Low Coverage Plans* |
|---|--------------------------------|-------------------------------|
| BEST Life & Health Insurance Company (n=All 100) | 2 | 2 |
| Renaissance Life & Health Insurance Company (n=All 100) | 2 | 2 |
| Truassure Insurance Company (n not available) | 1 | 1 |

*High coverage plans have higher premiums with lower copayments & deductibles. Low coverage plans have lower premiums with higher copayments & deductibles.

An additional seven counties had access to a low coverage plan administered by Dentegra Insurance Company. Only one (Richmond County) of the seven counties was considered rural or underserved. Another 40 counties had access to a second low coverage plan administered by The Guardian Life Insurance Company. Seven of the 40 were designated as rural or underserved: Anson, Bladen, Greene, Montgomery, Richmond, Sampson, and Warren. Richmond is the only rural or underserved county to have access to all dental insurance plans. It is in close proximity to both Pinehurst and Fort Bragg,

which are significant tourist and military communities, respectively, which might explain the market penetration of dental plans.

ADVANCING ORAL HEALTH INTERPROFESSIONAL PRACTICE

Innovations in Oral Health Equity through Interprofessional Practice. North Carolina has demonstrated considerable leadership in the area of pediatric oral health interprofessional practice, particularly with application of fluoride varnish for children by primary care medical practices.^{9,10} Significant leadership came through the state's funding from the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. The state's CHIPRA Oral Health Workgroup established three goals: increase rates of fluoride varnish, promotion of risk assessment tools, and strengthened relationships between dental and primary care providers in underserved communities. As a result, the state implemented "Into the Mouths of Babes" initiative that trains primary care providers on interprofessional practice for early childhood populations. A project toolkit is available at <https://www2.ncdhhs.gov/dph/oralhealth/partners/IMB-toolkit.htm>. Two tools worthy of highlighting in this overview are the Priority Oral Health Risk Assessment and Referral Tool and referral guidelines, both of which are available at the toolkit link. Given the success North Carolina has experienced with Into the Mouths of Babes, the state's public health agency is working with partners to implement Into the Mouths of Moms (I-MOM).

As a result of its innovative approach to early childhood oral health interprofessional practice, North Carolina is showing improvements in oral health equity for historically disparate children. Their work is published in both *Health Affairs*⁹ and *Pediatrics*¹⁰ and demonstrates improvements in receipt of primary care-based oral health prevention services and decreases in caries. Public-private partnerships with philanthropic partners such as The Duke Endowment and the Blue Cross Blue Shield of NC Foundation support interprofessional practice.



Background: As of 2015, an estimated 2.7 million children (age less than 18 years) lived in Pennsylvania. The majority (77%) of residents in Pennsylvania consider themselves white non-Hispanic, with 7% identifying as Hispanic and 12% identifying as Black or African American. Statewide, 74.5% of parents reported their child’s oral health as excellent or very good; 78.7% reported that their child had received a preventive dental visit in the past year.² As reported by the American Dental Association, 68% of dentists in Pennsylvania participated in Medicaid for child services in 2014, compared to 42% across the U.S.³ While Pennsylvania does not have any whole-county dental health professions shortage areas, 42 of its 67 counties are shortage areas for the low-income population.

IMPROVING ACCESS TO ORAL HEALTH CARE

Safety Net Capacity. There are 28 Federally Qualified Health Centers (FQHCs) with dental programs serving Pennsylvania. Nine health centers in PA received HRSA Oral Health Service Expansion awards for a total 2016 award amount of \$3.3 million. Five of the nine grants went to FQHCs in Philadelphia. The remaining grants were awarded to sites in Pottstown, Kennett Square, Sharon, and Carlisle, PA. To ensure successful operations of FQHC dental programs in the state, the Pennsylvania Primary Care Association is a grantee of the DentaQuest Foundation’s initiative, Strengthening the Oral Health Safety Net. This public-private partnership seeks to improve the financial performance and clinical outcomes demonstrated by FQHCs. A second example of a public-private partnership is the state’s grant support for community-based primary care programs. These state funds are used for establishing or expanding primary care services. Recently, the state has seen a shift in funding from medical care exclusively to oral health services and dental practices receiving about half of the annual allocations.

New Workforce Model. There are reportedly 36 organizations that use Public Health Hygiene Practitioners in Pennsylvania. This new workforce is able to work in primary care settings to provide select dental services (e.g. fluoride varnish as a part of a well child examination) and receive reimbursement for the care.

Dental Insurance through the Marketplace. Pennsylvania residents have access to medical insurance plans that include pediatric dental benefits, however it is unclear how many children are enrolled in such plans. Depending on county of residence, Pennsylvanians also had access to between 16 to 29 stand-alone dental insurance plans through four insurance companies in 2015 as summarized from HealthCare.gov.⁴ The availability of plans was not correlated to rurality. These stand-alone plans covered 9.8% of the state’s children.⁹

| Insurance Company (n=Counties Served of a Total of 67) | Number of High Coverage Plans | Number of Low Coverage Plans |
|---|-------------------------------|------------------------------|
| BEST Life & Health Insurance Company (n=67) | 2 | 2 |
| Capital Advantage Assurance Company (n=21) | 0 | 4 |
| Dental Care Plus, Inc. (n=35) | 2 | 2 |
| Dentegra Insurance Company (n=32) | 1 | 1 |
| Dominion Dental Service, Inc. (n=40) | 4 | 4 |
| DSM USA Insurance Company Inc. (n=35) | 2 | 1 |
| Humana Insurance Company (n=67) | 0 | 1 |
| The Guardian Life Insurance Company (n=39) | 0 | 1 |
| The PA Dental Corporation dba Delta Dental of PA (n=67) | 2 | 2 |
| Truassure Insurance Company(n=67) | 1 | 1 |

*High coverage plans have higher premiums with lower copayments & deductibles. Low coverage plans have lower premiums with higher copayments & deductibles.

ADVANCING ORAL HEALTH INTERPROFESSIONAL PRACTICE

Pennsylvania has identified how to leverage opportunities within managed care to promote oral health interprofessional practice. Examples include:

- *Managed Care Influences.* Nearly all children aged 21 years and younger enrolled in Medicaid participate in managed care. Oral health has been included in the state's Managed Care Organizations (MCOs) since 1997. It was reported that MCOs will continue to be encouraged to incorporate oral health into their networks to ensure prevention and referrals so that the MCOs managed the handoff between primary care and dental.
- *Head Start and MCOs.* The state Medicaid program has a Head Start linkage through an initiative called Healthy Choices. Through this initiative, managed care organizations are facilitating collaborations between dental and medical providers. It was reported that there are about 3,500-4,500 in children in Pennsylvania Head Start all of whom would benefit from greater oral health interprofessional practice. Public-private partnerships exist among the state American Academy of Pediatrics Chapter, Head Start, and local dentists to address early childhood oral health.

Pennsylvania is also one of three states currently implementing the MORE Care initiative of the DentaQuest Institute, which builds on leadership at the State Office of Rural Health to facilitate adoption of oral health interprofessional protocols within rural health centers. This work began in 2016 and is reported by key informants to be off to a promising start.



Background: As of 2015, an estimated 1.1 million children (age less than 18 years) lived in South Carolina. The majority (68.4%) of residents in South Carolina consider themselves white non-Hispanic, with 5.5% identifying as Hispanic and 27.6% identifying as Black or African American. Statewide, 75.7 % of parents reported their child’s oral health as excellent or very good; 76.6% reported that their child had received a preventive dental visit in the past year.² As reported by the American

Dental Association, 48% of dentists in South Carolina in Medicaid for child services in 2014, compared to 42% across the U.S.⁶ Twenty-three (23) of South Carolina’s 46 counties are geographic dental health professional shortage areas.

IMPROVING ACCESS TO ORAL HEALTH CARE

Safety Net Capacity. As of January 2016, South Carolina had 21 Federally Qualified Health Centers (FQHCs), 10 of which provide oral health services. Six health centers in SC, all in rural communities, received HRSA Oral Health Service Expansion awards for a total 2016 award amount of \$2.275 million. The state has had a successful public-private partnership with the DentaQuest Institute’s Safety Net Solutions program to improve the financial performance and clinical models for five FQHCs that have improved capacity within existing sites.

Dental Insurance through the Marketplace. Medicaid covers nearly 630,000 children aged 0 to 18 years with approximately 330,000 receiving dental care in 2015. Medical insurance plans are available in South Carolina that provide dental benefits to children, however, the enrollment rates are unavailable. South Carolinians in all 46 counties had access to 11 stand-alone dental insurance plans through three insurance companies in 2015 as summarized from HealthCare.gov.⁷ The dental stand-alone participation rate among children for the state was 7.7%.⁹

| Insurance Company | Number of High Coverage Plans* | Number of Low Coverage Plans* |
|--|--------------------------------|-------------------------------|
| BEST Life & Health Insurance Company | 2 | 2 |
| Delta Dental of Missouri | 1 | 2 |
| Renaissance Life & Health Insurance Company of America | 2 | 2 |

*High coverage plans have higher premiums with lower copayments & deductibles. Low coverage plans have lower premiums with higher copayments & deductibles.

An additional 15 counties had access to a low coverage plan administered by Dentegra Insurance Company. Only two of the counties with this plan were considered rural or underserved: Lee and Williamsburg.

ADVANCING ORAL HEALTH INTERPROFESSIONAL PRACTICE

Innovations in Pediatric Oral Health Equity through Interprofessional Practice South Carolina has had challenges with broad adoption of oral health interprofessional practice, specifically with application of fluoride varnish in primary care settings, despite Medicaid reimbursement for the service.¹¹ In response

to this and pronounced rural inequities around oral health, a rural oral health inequity portfolio has been developed that advanced oral health interprofessional practice through academic education enhancements and practice transformation strategies, delineated on the following page:

- *MORE Care*. As in Colorado and Pennsylvania, South Carolina is participating in the Medical Oral Expanded Care project through a public-private partnership with the DentaQuest Institute. South Carolina has served as the initial demonstrate state since 2014. The state's College of Dental Medicine, State Office of Rural Health, Rural Health Research Center, Dental Association, public health agency, and others are working with the DentaQuest Institute to implement the Medical Oral Expanded (MORE) Care Initiative.
- *ROADS*. The same MORE Care partners are implementing a HRSA Workforce grant, Rural Oral Health Advancements through Delivery Systems. While the MORE Care project is led by the SC Office of Rural Health and focuses on rural health clinics' implementation of oral health interprofessional practice, ROADS addresses the dental delivery side. The state's College of Dental Medicine is leading this grant with previously mentioned partners on supporting rural dentists on collaborative referral management pathways with primary care partners.
- *ROADTRIP*. The state's College of Dental Medicine received another HRSA Predoctoral Training Grant in General, Pediatric, and Public Health Dentistry and a State Oral Health Workforce Grant. The project, Rural Oral Health Advancements through Interprofessional Training (ROADTRIP) has two components. One is creating a certificate program for dental students and residents in safety net dental practice which will provide specialized training that improves the clinical and cultural expertise and the business acumen for sustaining practice in underserved areas.

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Technical Notes

State Office of Rural Health Directors and leadership from state primary care associations in six states were interviewed to describe the stability of the dental safety net in rural communities, Medicaid reimbursement policies or legislative actions that promote oral health equity for rural children, and public-private partnerships for leveraging improvements in rural oral health. Interviews were conducted by telephone and were semi-structured in format. We had planned on exploring how children access dental benefits in each state and how that access differs for rural versus urban children. Unfortunately, we were unable to capture this information from our interviews, nor could the information be found through other public sources.

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