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Hello everyone, and thank you for attending today's webinar, "Reducing Early Childhood Tooth Decay: Approaches in Medicaid." Before we begin, we wanted to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets that you can use. You can expand each widget, as well as your slide area, by clicking on the "maximize" icon at the top right of the widget panel or by dragging the bottom right corner of the widget panel or slide area.

A copy of today's slide deck is available in the resource list widget, indicated by the green folder icon at the bottom of your screen. If you have any technical difficulties, please click on the help widget. It has a question mark icon and covers common technical issues; however, you can also submit technical questions through the Q&A widget.

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Now I'd like to introduce Meg Booth, Director of Policy for the Children's Dental Health Project. Meg, you now have the floor.

Thank you, Brice. Good afternoon and welcome to the Center for Medicare and Medicaid sponsored webinar titled "Reducing Early Childhood Tooth Decay: Approaches in Medicaid." I'm Meg Booth, Director of Policy at the Children's Dental Health Project, and I'll be your moderator for today's webinar. This topic has been chosen to examine opportunities in a rapidly transforming healthcare delivery system to integrate oral healthcare for young children into efforts that are promoting a higher quality of healthcare for healthier populations at a lower per capita cost. Medicaid and CHIP have the options to approach the problem of early childhood caries, which is a preventable disease that causes tooth decay, to focus on prevention and disease management, rather than paying for costly treatment that, alone, has little impact on the progression of the disease.

This 90-minute webinar calls upon experts in the field of early childhood caries and CMS's own Oral Health Initiative staff to identify actionable strategies to preventing and managing early childhood caries within the Medicaid and CHIP enrolled population. In addition, we will hear from North Carolina about their experience adapting their periodicity schedule to support a medical/dental team approach to preventing and managing early childhood caries in their Medicaid program.

Our first speaker will be Dr. Burton Edelstein, Professor of Dental Medicine and Health Policy Management at Columbia University Medical Center, the Chair of Population Oral Health at the College of Dental Medicine at Columbia, and Founder and Chair Emeritus at the Children's Dental Health Project. We'll follow that with two presenters from CMS, Laurie Norris, the Senior Policy Advisor and Coordinator for CMS's Oral Health Initiative, and Susan Ruiz, the EPSDT lead from CMS's own Region Nine Office in San Francisco, California.

We will then hear from two speakers from the North Carolina Department of Health and Human Services, Miss Darlene Baker, the Lead Dental Policy Analyst in the Division of Medical Assistants or Medicaid Agency, and Kelly Close, the Preschool Oral Health Coordinator and Oral Health Section other division of public health.

We will take a limited number of questions between the presenters and have additional time at the end. Feel free to send questions by using a chat box in your screen. We'll get to as many questions as time permits. So let's get started.

I've asked Dr. Edelstein to respond to a series of questions that provide the basics on early childhood caries, how the disease can be prevented and managed, and how medical and dental professionals will address the condition. Welcome Dr. Edelstein. Let's get started with the basics.

Thank you very much, Meg. Policymakers need to know, in answer to the question what do policymakers and Medicaid directors and managers need to know about ECC; firstly, they need to know what it is. By definition, it is tooth decay in children under age six years of age. But that itself, the fact that these kids have tooth decay before their sixth birthday says a lot. Children who've figured out how to get cavities at such an early age are experts in making cavities, and because past cavity experience is the best predictor of future experience, children who have this problem are set up for a lifetime of dental troubles, unless something is done about it.

ECC is common, it effects one in four U.S. toddlers and preschoolers, and it is variable in its extent. So this estimate of 24 percent from CDC includes children who have only a modest experience with tooth decay, as well as those who have rampant destruction of the majority of their primary teeth. Most important is that it's consequential, it really matters. Otherwise, we would not be here today to talk about it.

It impacts children leading to troubles eating, sleeping, behaving, attending to learning. It impacts families dealing with the child in distress, seeking care, and missing work. It impacts financing and delivery programs, as costs are disproportionately allocated to this problem amongst young children. And it's taxing, it's taxing on both financing and delivery systems, as there are a range of challenges inherent in caring for children so young with a disease as compromising as this is. Yet, it is overwhelmingly preventable, and when it's not prevented, it can be managed and suppressed, and even arrested, stopped from progressing.

Think of interventions as a spectrum, from primary prevention all the way through to disease arrest. It's amenable to changes in healthcare delivery and financing, that, as with the larger health-care system, are seeking better health outcomes at lower cost through smarter care.

And I'd like to add for the governmental policymakers on our call today that there's also a tremendous interest in your communities and an infrastructure of people already working on this problem through head start, through WIC, local initiatives, research endeavors, demonstrations, and so much more.

So you already have a ready and able infrastructure to support state and local policy efforts in prevention, disease management, and care management. I noted that ECC is common. This gives you an idea of how common it is and how it progresses across age cohorts. So based on earlier NHANES data and published in pediatrics, this shows that one in ten children, 11 percent, have visible cavities by age two. That doubles to one in five children at age three. It continues to increase, affecting one in three children by age four, and it begins to approach one in two by age five.

The most recent NHANES data, updated in 2011-'12, continues to report that about one in four children across these age groups taken together have early childhood tooth decay. And importantly, 43 percent of those who have this experience with tooth decay at such a young age have untreated cavities. If we translate that into the numbers of children, that's one in ten toddlers and preschoolers in the U.S. have untreated cavities. It matters.

Why does it matter? Well this slide highlights why it matters, and why it matters in particular to Medicaid and CHIP policymakers and public health officials, as well as to children and families and the dental teams and medical teams that care for them. Not only does this preventable and manageable disease result in excess cost, but it disrupts families. It leads to poor appearance that can lead to stigma. It relates

to acute pain and infection, at such an early age and with that dysfunction, and too often trips to the emergency room, the emergency department, for relief.

Now that inclusion of death there may look like it's overly dramatic, but dental infections can travel north to brain and cause infections there, and south to impede breathing and other functions. And perhaps even more tragic is that every year we learn about an occasional child who succumbs to either significant damage or even death in anesthesia and sedation mishaps, when desperate efforts are made to address their acute problems. So, in sum, this is the problem that really matters.

The next question that was raised for me was, can it be prevented? And once it takes effect, if it hasn't been prevented, can it be stopped? Well, to prevent and stop ECC progression, it's helpful to better appreciate the underlying caries disease process.

Here in this slide we define caries as a chronic disease process that then leads to cavities, making a distinction between the process that causes the cavity and the cavity itself. And that's important because fixing the cavities themselves, important as it is for form and function and aesthetics, does not stop the underlying disease process.

Importantly, caries is a disease of the child. It's a disease of the child's mouth. It's expressed on the teeth, but it takes place in the mouth. It can also be considered a disease of the family, since its determinants occur at the family level. It occurs in the home. It occurs in the playground. It occurs in front of the TV and on the street, wherever children are eating or snacking decay-causing foods and drinks. Essentially it's an imbalance, as shown in this slide, an imbalance of destructive processes whereby sugar is transformed into acid by decay-causing bacteria that then pulls the mineral out of teeth, a process referred to as "demineralization." And then the natural healing efforts of our mouth, bringing saliva and minerals, especially when abetted by fluoride, to put those minerals back in.

Tooth decay is a dynamic process, and when it's in balance the tooth surface stays intact, but when it's not in balance, we have more loss of minerals then gain of minerals, and the resultant, formation of a cavity. Risk for the disease is highly variable, but it tends to be very stable within any given child, unless there's an intervention to change that risk. There are multiple risk tools out there, and they all relate to these basic factors of re-mineralization and demineralization, and all of them are good enough to now classify children as high, medium, or low.

So here is a child showing off the problem that already exists on those front teeth, because cavities, again, are the holes in the teeth that results from the chronic caries process. You can only imagine what this child feels like when they eat something hot or cold. It's very helpful to rely on a chronic disease model that's widely accepted, the Wagner's Chronic Disease Management Model, to get a sense of how we might approach this disease in addition to, and that complements surgical reparative intervention.

The sweet spot for caries management is that interaction showed in the black arrows. It's that interaction between a competent provider team and an informed engaged activated parent; that interaction that takes place when the team is effective as a counseling entity and the parent elects to take action on a daily basis at home, that's what can bring the disease process under control.

So the caries process can be treated separately from the cavity process, the cavity issue, by raising parents' awareness and education about the disease so they understand what they're dealing with, engaging the family effectively in day-to-day health behaviors by helping them set goals, and more important, develop family-specific action plans, and then assisting those families in adopting those behavioral changes, and then wrapping the family around that larger balloon in the diagram of community and health system supports.

The strategies listed here have as much relevance for the individual child and family as they do for the policymaker who is working to address this problem for the entire population. Two system dynamics' modeling efforts, sponsored by CDC and foundations, that have been published in 2012 with children and Colorado, in CDC's journal "Preventing Chronic Disease", and published just recently in 2015 in the

"Journal of the American Dental Association" for New York State Medicaid children, have looked at these various interventions to see what can work at both the individual and population level, that policymakers can adopt in order to dampen the prevalence of this disease. Fluorides are critically important because they facilitate that re-mineralization, that healing of the tooth. And that's available universally through community water fluoridation, where community water systems can support it. But it's also effective at the individual level using professionally applied fluoride varnishes and jells, whether provided by medical or dental teams, and most important of all that daily, daily use of fluoridated toothpaste at home that provides the constant drum beat of repair.

Counseling that's generic isn't very effective, but motivational interviewing style of counseling that really engages the family and helps them help themselves, that has been shown to be effective, and that, then, results in tailored family-level action planning that parents can carry out at home. Professional care is always an important complement to what happens at home. Here we have the primary care provider doing screening, counseling, and referral, as suggested by and studied by the United States Preventative Health Service Taskforce, and dental prevention visits, where both fluoride, pharmacological, and counseling behavioral approaches can come together. And, of course, when you combine multiple approaches, that's the best of all.

In doing the system dynamics analysis, what we find is that, in addition to community water fluoridation, which, without doubt, is critically important when possible, it's that daily use of home fluoride toothpaste and motivational interviewing that have the best ROI, the best return on investment, and the best results for the efforts expended.

The next question asked was, who's effected, who has this problem, and why does it matter in particular to the Medicaid and CHIP policymakers? Risk takes into consideration both epidemiology and etiology. At the population level, children from low-income families typically covered by Medicaid and CHIP have higher rates of disease. A very rough over-simplification of the epidemiology that's handy for us to just kind of hold onto, because it paints a picture, is that low-income kids, under 200 percent of poverty, are twice as likely to have early childhood caries. They tend to have twice the extent of the disease when they do. They're twice as likely to have acute pain and infection experience, but they're less likely, in many cases, half as likely, to obtain dental care. And because families share risk factors, children of effected parents and siblings are also at higher risk, and because you know the nature of the disease, the exposures to cariogenic eating and the availability of fluorides become critical issues in who has early childhood caries.

The next question is, how it is it typically treated? Well it's typically treated by a combination of generic counseling and dental repair. The problem is that, as already mentioned, dental repair doesn't stop the underlying process, and that's why the international dental literature suggests that 53 to 79 percent, so half to four-fifths of all children who have a severe enough experience that they go to the operating room to get multiple teeth fixed, those kids have new cavities within one to two years.

The question is, can we manage this problem even before it occurs through prevention, and can we manage it well, even after it occurs, by management or suppression? So prevention works by assuring that there's balance between the decay-causing and the healing properties that occur in the mouth, that dynamic process. And management occurs when there's already an imbalance, and we work with the families to get back into balance. So back into balance by managing diet and eating patterns, diet content for cariogenic foods and eating patterns to give the teeth some time to relieve and restore between eating exposures, use of fluorides, improved oral hygiene, and perhaps most valuable of all would be raising parent's evaluation for oral health, because once they get it, once they understand how the disease works, and once they care about how to deal with it and their responsibility in dealing with it, once salience is raised, then they intuitively know how to manage the day-to-day risk factors and protected factors.

The next question deals with how the profession is currently dealing with it relative to how they're deal with it in an increasingly evolving way, and there is a shift underway. The shift underway is from a focus on surgical management, complemented with some counseling, to meaningful motivational interviewing

and pharmacological management, and involving primary care medical personnel in order to triage the kids, pick out those kids who either already have signs of the disease, already have cavities, or already have the constellation of risk factors that are putting them into trouble. And then setting them into care paths that are specifically appropriate to their level of risk. More intensive intervention for kids who are at higher risk, less intensive intervention for kids at lower risk, and then tailored counseling that gets down to the level of the individual family and what works for them. And, clearly, we, in the dental profession, and we, in the medical profession, can benefit from engaging with others whose specialty is behavior change at the family level. So this inter-professional care extends beyond medicine and dentistry to also include the helping professions; health educators, social workers, nutritionists, behaviorists, and also the peer counselors, including community health workers, Head Start workers, WIC personnel, community dental health coordinators, and the community engagement component of what dental therapists are trained to do.

So chronic disease management principles, that Wagner model, when applied to ECC, have been shown to work. They've already been shown to work in reductions in pain, reductions in cavity recurrence, and reductions in the number of kids having to be treated in the operating room under general anesthesia. There's a fair amount of supportive governmental action to work with and assist policymakers across federal agencies. I've already mentioned that the United States Preventive Services Task Force has a recommendation on prevention of dental caries in children from birth through age five, these children we're talking about, and there, they recommend the primary care medical providers, that there is evidence to recommend that primary care medical providers manage fluoride prescriptions and apply fluoride varnish, and they have taken a look at, but found insufficient evidence so far about counseling, perhaps because generic counseling, as opposed to motivational interview counseling, makes a real difference.

NIH, both at the dental and craniofacial institute and the institute on Minority Health and Health Disparities, has been supporting ECC management research. CMS, through its Innovation Center, the Center for Medicare and Medicaid Innovation, is now supporting ECC management demonstrations. HRSA's Bureau of Health Workforce has actively engaged the Institute of Medicine Recommendations for holistic patient-centered care that is delivered in inter-professional and interdisciplinary ways, and I failed to list here, but want to certainly mention HRSA's Maternal and Child Health Bureau has similarly been engaged, supporting a trove of information at the National Maternal and Child Oral Health Resource Center, and a number of publications on the Web from the former National Maternal Child and Oral Health Policy Center.

MCHB has also supported AAP's Bright Futures guidelines and is helping to track those states that are financing physicians involvement in ECC management. And then, of course, the CMS Oral Health Initiative itself, which brings you the webinar today, and all the activities across state Medicaid programs, particularly those that have been engaging physicians in ECC management and oversight.

Similarly, there is a range of support from provider associations. The American Academy of pediatric dentistry has extensive guidelines and care paths for management of ECC. The American Dental Association, the public health people, in affiliation with the Association of State and Territorial Dental Directors, have population-level guidance. The Academy of Pediatrics, as I've already mentioned, and the family physicians, all having involvement and engagement, encouraging us to think about this from the family and child perspective and not just from the dental and dental repair perspective.

The next question relates to whether there's a disconnect between these guidelines and practice, and, indeed, there is a disconnect, in part, because dentistry comes from a surgical heritage, in part, because the experience of dental education is focused on learning techniques. Despite education around holistic care, the experience of dental education is very much technical, and we, of course, have the “silo”-ing away from medicine, with dentistry having its own coverage and benefits, its own workforce, its own care site, and, like much of medicine, still grounded in pay for volume rather than pay for value.

So this summary slide takes a look at the traditional past, as well as potential innovation future. As I've mentioned, the traditional looks to the dental team with supplement from the medical side, but the new provider teams look to the healing professions, the helping professions, and lay health workers. The focus

is shifting from repair with some generic counseling to true disease management and repair as needed, and the payment is just beginning to envision how to shift from volume incentivized, based on procedures, to value incentivized, based on outcomes. And, of course, Medicaid EPSDT holds all of the promise, because it's so broad, has all of the promise to be able to implement change.

Finally, let me recap some of the key points, noting that ECC is common, it's chronic, it's progressive, and it matters. It disproportionately affects the very populations that are of concern to Medicaid and CHIP policymakers and public health officials. It's largely preventable, and very considerably, if not completely, manageable. It's not well managed by traditional surgical approaches, but it holds strong promise and some good evidence already that it is best managed as a chronic disease by team-based, patient-centered, family interventions, that involve the family in the context of their community and build around behavior change.

So I thank you very much for the opportunity to share this information with you. It's impossible to recognize all of the terrific work underway by so many on this webinar today, but I am hopeful that this overview helps orient policymakers to the problem and allows us to think both in terms of individuals and their families, as well as populations of children affected. Thank you.

Thank you, Dr. Edelstein. I appreciate all of the information you provided. I'm going to go to two questions really quickly, before we move on to CMS, that are related, and they have to do with sort of technical sort of inside the mouth of what's happening. So one of the questions that I'm going to sort of combine two questions I think that you might be able to answer together has to do with the early childhood caries process, beginning with the mother, and whether there is caries-specific bacteria that's transmitted to an infant. And to go along with that is sort of whether the flora in the child's mouth is different when a child is identified with early childhood caries. So can you address what's going on in the mouth of both the mother and the child, and if there's differences going on?

I think the best way to think about this is starting with the term ecology, because the ecology of the mother's flora, the bacteria that constitutes the mother's mouth, and the ecology of the child, are closely related. There are a host of different bacteria that have the capacity to both produce acid and then, having produced acid, live in that environment. So both acidogenic that is produce acid, and aciduric, that they survive in an acid environment, so they can produce more acid to dissolve the teeth.

The way that children acquire the bacteria in their mouths is from vertical transmission, typically from mothers, and so there is a strong familial relationship from mothers to children, and some of the interventions that we took a look at in the system modeling are those that deal with trying to suppress the mother's decay-causing bacteria so that she becomes less of a competent reservoir to pass that on to the kids.

Now in terms of a particular bacteria, no, there's a whole constellation of bacteria that are capable of doing this. But there are a couple of bacteria that are sort of signal or useful in monitoring the process, and there are some tests that are used for assessing that bacteria in both the mother and the child's mouth. And those tests have been found to supplement and enhance the value of some of the risk assessment tools that are out there.

Great. Thank you so much, Dr. Edelstein. We're going to move on to the next set of presenters and come back to questions as I see them rolling in. So we're monitoring them and we'll get to many of them, either after CMS's presentation or at the end of -- after North Carolina’s. So, Susan and Laurie, you're up next.

We've heard from Dr. Edelstein that children in Medicaid and CHIP stand to benefit from services designed to prevent and manage early childhood caries, and that clinical guidelines already exist to help states put these approaches into practice. You both work in the dental program at CMS and are promoting the oral health initiative. Many of the members of our audience today are deeply involved in the state's effort to redesign their healthcare systems to provide higher quality healthcare services, resulting in improved health outcomes at lower per capita costs.

Laurie, can you talk a little bit about how preventing and managing approaches to early childhood caries aligns with these broad health systems' reform objectives?

Sure. Thank you, Meg, and please advance the slides twice. So let's begin by talking for a moment about the Affordable Care Act. Healthcare delivery system reform was built in to the Affordable Care Act. It contains an entire set of provisions seeking to achieve the three-part aim that Meg just mentioned; improving the experience of care for individuals, improving the health of populations, and lowering per capita costs. In order to achieve these goals, the law recognized that existing payment models and healthcare delivery systems would need to be reformed.

So the Affordable Care Act aims to move the healthcare system away from episodic fee for service payment approach and towards a coordinated model that is focused on delivering higher quality and lower-cost care. What Dr. Edelstein has just described for us is the children's oral health version of this reform. Instead of waiting for each parent to take their child to a dental office, we are thinking of ways to make those services more available in primary care and other settings. Instead of paying individually for each dental procedure, we are thinking of ways to reward better oral health outcomes. Instead of delivering one-size-fits-all preventive care, we are learning how to design care plans individualized to the specific child. And instead of using the surgical model of clinical care, we are exploring a shift to the medical model, where caries is understood as a chronic disease.

To help us achieve these Affordable Care Act goals for reform, CMS has adopted an agency-wide quality strategy. Some of the goals of the quality strategy, which seem particularly relevant to our efforts here, are to strengthen person and family engagement as partners in their care, to promote effective communication and coordination of care, and to promote effective prevention and treatment of chronic disease. In order to achieve these reforms in the fields of children's oral health, we will need to partner with all of you. Next slide.

So we currently spend billions of dollars every year on oral health care for children enrolled in Medicaid. But are we getting our money's worth? We know that the approach we are currently using has not been successful at addressing the disease in Medicaid enrollees. Persistently, fewer than half of those children receive a dental service in any given year, and there remains significant disparities in children's oral health along economic and racial lines.

Here, on the left, we see that more than 30 percent of children living in households with an income under 100 percent of the federal poverty level have untreated caries, whereas only about 14 percent of children in higher income households do. On the right, we see that children of Mexican origin have the highest levels of untreated tooth decay, and that non-Hispanic white children have the lowest levels, with African American children falling in between. Clearly, there is an unmet need. And, clearly, we do know how to do better from a clinical perspective. So how can we get from here to there? Next slide.

So it turns out that there are more than 100 early childhood caries pilot projects already underway nationally that are testing and proving that the chronic disease management approach can work. Take a look at this slide. How many early childhood caries pilot projects are operating in your state? The problem is we have not yet translated this better clinical approach to widespread improvement in population health. We also have not connected these pilots to Medicaid claiming, and so we're not able to measure or reap the benefits of the cost-saving potential. Next slide.

Thankfully, we have an excellent tool that can help us get there. The Medicaid benefit for children and adolescents, also known as EPSDT, which stands for Early and Periodic Screening, Diagnostics, and Treatment. This is a benefit. It is the benefit for children in Medicaid, and it provides a comprehensive set of healthcare services, with a particular focus on prevention for all children under age 21 who are enrolled in Medicaid. This benefit is already well suited to supporting a patient-centered approach to early childhood tooth decay.

As I mentioned, it's prevention-oriented and a keystone of this benefit is that each child is an individual and is supposed to receive the care that is right for them. We sometimes say the right care at the right

time in the right place for each child, and this includes oral health care. Children are entitled to receive oral well child care according to dental periodicity schedules adopted by each individual state Medicaid program.

In addition, children may receive additional or more frequent well child or preventative oral healthcare, as indicated by their oral health status. For example, a periodicity schedule may specify two oral health exams each year for the normal child. But a child at high risk for developing caries, or a child who has already developed caries and whose dental provider is working with the family to reduce the risk of further caries, could qualify for additional checkups, as recommended by the provider. In addition to periodic well care, Medicaid does cover for all children, at a minimum, relief of oral pain and infections, restoration of teeth, maintenance of the dental health, and medically-necessary orthodontic services. Next slide.

So this slide shows that there are two critical components to prevention and management of early childhood caries. The first is assessing a child's individual risk of developing the disease. That's the caries risk assessment that Dr. Edelstein spoke of. The second component is addressing that child's risk through an individualized care plan. In terms of the risk assessment it should be performed at certain recommended ages and intervals, and it involves looking at a combination of factors, including the family history of tooth decay, low socioeconomic status, diet, fluoride exposure, and tooth-brushing habits, as well as clinical findings, such as visible cavities or fillings.

The outcome of the risk assessment then feeds into the development of the care plan. The plan specifies how often the child should be seen for diagnostic purposes, for follow-up risk assessment, for changes and expectations regarding diet and fluoride exposure, and for steps to monitor existing signs of decay or to restore decayed teeth. However, risk assessments and individualized care plans are not yet widely used in Medicaid and CHIP, in part, because some policies and payment methods that predate current clinical guidelines do not explicitly support their use or are narrowly interpreted. These barriers can be addressed. Next slide.

Thank you, Laurie. Susan, to go to you, how can busy Medicaid and CHIP directors and the program managers within Medicaid begin to take action? Can you start with talking about some program rules and policies? Basically, what can states do without explicit approval from CMS but working within their own agency?

Well there are a number of steps that states can take. States have a lot of flexibility within the federal statute to design an oral health benefit that meets the needs of their children. Federal law establishes the framework with the standards and requirements states must meet. That's why Medicaid looks so different from state to state. You can look at your program manuals. There should not be explicit limits on services for children without procedures in place to go over and above those limits when medically necessary. For example, if a child has early childhood tooth decay, is it at risk for developing it, or has a disability that impacts their oral health, they should be able to easily have additional risk assessments, recall visits, and fluoride varnish authorized.

Many states already follow, and many doctors actively use Bright Futures. If states develop or align their provider handbooks with AAP guidelines, it simplifies the process for physicians. That way they don't have to do something special for Medicaid patients. Make sure doctors are provided with caries risk assessment tools and instructions for using them.

Bright Futures recommends that children receive a caries risk assessment at the six and nine month visits. Risk assessments should continue at the 12, 18, 24, 30 month and 3 and 6 year visits, especially if the child does not have a dental home. The USPSTF recommends the application of fluoride varnish to primary teeth of all infants and children, starting when they get their first tooth up to age five in primary care practices. Next slide.

You can make sure doctors know how and where to refer a child who is assessed as high risk or who has observable untreated caries. Referring to an actual practice is much better than telling a family to see a dentist, and the Insure Kids Now website has a state-by-state, plan-by-plan list of dentists who accept

Medicaid and CHIP. You can also reach out to your state AAP chapter to ask for their help. We know doctors are more eager to listen to other doctors than read program manuals, so make that connection in your state if it isn't already there.

Every state AAP chapter has a trained oral health advocate. You can work with your managed care plan to implement oral health performance improvement projects. A plan could develop a project to measure primary care providers and corporation with risk assessment and fluoride varnish at each well child visit.

General anesthesia and surgical restorations on a young child are quite costly, and everyone wants to avoid them. CMS will be, shortly, releasing tools to help states, in conjunction with our managed care plans, development and implement high quality oral health performance improvement projects.

In the same way that doctors can ask for more services or more frequent services in the general benefit package, so can dentists. Make sure dentists know that they can ask for extra services for kids when they believe those services are medically necessary. Next slide.

So what else can you do? You could develop a performance improvement project to track and improve oral health in your state's children. To do that, you will need to choose measures to track results. CMS tracks a few dental performance measures across states. Two of them are on this slide. These two measures are part of the child core set of quality measures. PDENT looks at the percentage of children ages 1 through 20 receiving a preventative dental service, and SEAL looks at the percentage of children ages 6 through 9 who receive a sealant on a permanent molar.

Reporting the measures in the child core set is voluntary, and while CMS calculates PDENT for each state using other information submitted to us, we really encourage states to choose to report on the new sealant measure in January 2016. CMS reports the results of the child core set measures every year by measure and by state in the annual report on the quality of care for children in Medicaid and CHIP. The report is available on Medicaid.gov. More information about the measures can be found at the link on the slide.

Thanks, Susan. Laurie, back to you. It's one thing for states to have some sound policies and payments methods on paper, but how can states help ensure that Medicaid and CHIP medical and dental providers implement the prevention and management approaches that Dr. Edelstein had already described in his presentation?

Well let me start by saying that almost every state has already adopted a policy to reimburse medical providers for delivering certain oral health services to young children, such as performing oral health risk assessments and applying fluoride varnish, and this a huge step forward. However, having those policies in place has not, by and large, been sufficient to transform medical practice.

This slide shows the proportion of children ages one to five who received an oral health service, such as a fluoride treatment, from a primary care medical provider in each state in 2013. And I'm sure it's hard for you to decipher it, so I'll do a little bit of that for you. On the left you can see that we have a few fairly high-performing states -- Washington State, North Carolina, and Maine -- but even these states barely reach one in five or one in four children. The national average is just 6.2%, and many states, as you look over to the right of this slide, they barely register at all. Clearly, we have only just begun to get physicians involved in providing oral health services to young children in Medicaid despite reimbursement policies being in place. Next slide.

So obviously we cannot change clinical practice without engaging directly with providers. Pediatricians, family physicians, dentists, dental hygienists, nurses, nurse practitioners, all of them have a contribution to make here. They all have national organizations and state chapters. I've listed a few of them here. Of particular note is the fact that the American Academy of Pediatrics has a long-standing policy of training an official oral health advocate in each of its state chapters. We applaud the AAP for this approach and encourage state Medicaid agencies and all oral health stakeholders to identify and connect with this person in your state.

We also have examples in two states that have been working hard on early childhood tooth decay for more than a decade and have seen results. You will hear from North Carolina in a moment, but they will describe today only a small slice of their Into the Mouths of Babes Program. I urge you to read up on it if you're not already familiar with it. North Carolina used a primary-care-based approach. Washington State has used the dentist-focused approach in their access to baby and child dentistry program. But you can see from their numbers on the previous slide that they have also seen results on the primary care side.

Lastly, more than two dozen states have an improvement partnership. An improvement partnership is a state or regional collaboration of public and private partners that uses measurement-based efforts and a systems approach to improve child health outcomes and the quality of their healthcare. These entities can be resources for you in working with providers in your state to transform clinical oral health practice from the surgical model to the clinical model. If you click on the link on the slide here, you can tell whether your state has an improvement partnership. Next slide.

Thanks, Laurie. So, before we talk to North Carolina, can we talk about what resources are available from CMS to help state Medicaid and CHIP programs think through some of the policies and system changes we've discussed?

Sure. CMS has just published three new issue briefs on early childhood tooth decay. Hopefully those of you on today's webinar received links to those documents. These briefs are intended as tools for advocates and other stakeholders to use in their conversations with state health policy leaders, such as governors, Medicaid directors, state legislators, and staff, to begin to shift the conversation in the direction of achieving more patient-centered care, leading to better health outcomes for kids.

The first document is a four-page primer on early childhood caries itself, and on the new approaches to managing early childhood caries as a chronic disease. It covers the basic territory that you heard from Dr. Edelstein this afternoon. It also introduces approaches to emphasizing prevention, assessing and addressing risk, educating and engaging parents, and supporting providers. The second, "Leading Steps for State Policymakers," is a two-page action overview for high-level officials and policymakers. And the third, "Strategies for State Medicaid and CHIP Dental Program Managers," is a little longer, five pages, and it offers specific policy approaches that states can use to support the adoption of the prevention and management of early childhood caries in Medicaid and CHIP. It also includes highlights of state examples in the areas of promoting fluoride varnish application and oral health risk assessments, developing individualized care plans for high-risk children, family education and engagement, and performance measurement and quality improvement. We encourage you to check these resources out at the link on the slide, and we hope that you find them to be useful in your work in your state to promote these new approaches. Next slide.

We have several other tools that will soon be coming available; two manuals and a template that will help states and health plans develop and implement impactful oral health performance improvement projects in managed care. The topic that we're talking about today is a prime set of the types of interventions that could be implemented in a performance improvement project. We debuted these tools on two other webinars earlier this month, and you can access the recordings of those webinars at the links on these slides.

The second set is the issue briefs that we're talking about today. Third, we will be releasing a set of web-based training modules to help state staff understand how to correctly collect and report their dental data on what we call our Form CMS 416. It's how CMS tracks how well states are doing in delivering dental services to children in Medicaid. And finally, we're developing a Medicaid dental contracting toolkit to help states leverage their contracts to get the most out of their Medicaid dollars. Next slide.

Thanks, Laurie and Susan. I want to go to one question that's just more of a clarification that I think would be pretty easy to answer. But when talking about different groups that are doing counseling, we continue to refer to sort of medical providers, but the question was, does it need to be just medical providers in the

general sort of or very clinical sense, or nurse practitioners, and nurses, social workers dietitians, also people we should look at for counseling on early childhood caries also?

So I'll start and answer to that, but, Susan, you'll probably want to jump in as well. My understanding is that any licensed and qualified provider for whom the service that they're providing is within the scope of their practice can provide whatever the services we're talking about. So I think all of those types of providers that you just mentioned, Meg, could be potential providers, as long as they're licensed to do the sort of thing that they're actually being called upon to do.

Susan, do you have anything to add to that?

Only that you would need to check with your state's Medicaid program to see who they have enrolled as providers, because they do need to be a Medicaid-enrolled provider, providing medically necessary service.

Great. Thank you. We're going to move on to North Carolina, and then we'll open it up for numerous questions after Darlene and Kelly have been able to tell us what's going on in North Carolina, since they have taken several important steps to bring early childhood caries prevention and disease management approaches to their Medicaid programs.

Many in our audience may be familiar with what Laurie had just previously mentioned, their Into the Mouth of Babes program, which works closely with physicians to address the oral health of young children. Miss Baker and Miss Close, both from the Department of Health and Human Services, but through their Medicaid and Public Health Agencies, are going to share their experience in revising their Medicaid dental periodicity schedule to support a team-based approach to early childhood caries prevention and management.

Good afternoon, Darlene and Kelly, how you?

Good afternoon.

Hi. Thank you. Can you give our audience a little background on North Carolina's decision to revise their Medicaid dental periodicity schedule? How did the periodicity schedule figure into the state's efforts to prevent and manage early childhood caries?

The oral health periodicity schedule begins at the time of tooth eruption. Dentists should follow recommendations for the initial oral health screening and periodicity for healthy children, as issued by the American Academy of Pediatric Dentistry, or AAPD. Primary care medical providers should follow the recommendations for preventive oral health for pediatricians cited in the American Academy of Pediatrics Bright Futures periodicity schedule.

These services that PCPs render in visits with children up to age three and a half, include caries risk assessments, fluoride supplementation, anticipatory guidance, dietary counseling, injury prevention counseling, and age-specific oral hygiene instructions. For fluoride varnish application, dentists can bill every six months from the age of tooth eruption until the child turns age 21. PCPs can bill every 60 days, starting at the age of tooth eruption, with a maximum of six visits in the Into the Mouths of Babes Program before age 42 months. Next slide.

Why are periodicity schedules important? They establish the standard to meet early and periodic screening, diagnostic, and treatment services for the beneficiaries and for the providers. They are a benchmark that other organization, for example, Head Start, look to for guidance. They are also an important benchmark to strive to achieve program success. If all children are receiving periodic care every six months from a dentist, then reaching the CMS five-year goal of a 10 percentage point increase in preventative services increase in children ages 1 to 20 should follow. They are the foundation to build upon to introduce other innovative strategies to achieve success. Adherence to the periodicity schedule makes it easier to plan initiatives for program improvements. Next slide, please.

Intuitively, we all know that preventative oral health care is good for all people, but most importantly, for the disadvantaged who seem to bear a disproportionate share of the burden of disease. Regardless of the long-term potential cost savings, it is the right thing to do for a lifetime of better oral health. Many studies demonstrate that poor oral health in the primary dentition is the predictor for poor oral health in the permanent dentition. Prevent early childhood caries at a young age and chances are greater that the child will grow up to be an adult with good oral health. Next slide, please.

There are two preventive techniques in dentistry with a great deal of evidence-based support for the prevention of caries; fluoride varnish and sealants. Our state Medicaid CHIP dental program continues to cover the use of sealants on primary and permanent first and second molars. We have an outreach program with our primary care medical providers in the community care of North Carolina to encourage them to promote sealant use in young children. Of course North Carolina is well known for its pioneering primary medical provider fluoride varnish program Into the Mouths of Babes, or IMB for short. Despite its focus on delivering important preventive oral health care to infants and toddlers in the medical office, North Carolina Medicaid looks forward to a day when all Medicaid-eligible children will be able to access care in a dental office by their first birthday. We support the establishment of a dental home at an early age. Next slide, please.

Great. Thank you, Darlene. Darlene, can you talk a little bit about when and how the periodicity schedule changes were made and sort of what that entailed to make changes to your periodicity schedule?

In North Carolina Medicaid we have a unique way of making policy changes in lieu of administrative rulemaking. The North Carolina general assembly passed legislation to make the policymaking process less cumbersome for our agency. Our clinical advisory body, the physician Advisory Group, or PAG for short, is composed of experts from many disciplines, including a dental subcommittee. The PAG reviews policy changes and makes recommendations based on their many years of experience in their respective fields. The periodicity schedule was reviewed by the PAG dental committee and approved in the late summer of 2011. There were several experts in children's oral health on the PAG dental committee. Next slide, please.

Like proposed administrative rules, our proposed policy changes are posted for public comment. After the public comments were addressed, the periodicity schedule was implemented on November 1st, 2011. The Division of Medical Assistants published links to the periodicity schedule in the online help check or EPSDT provider manual, and included information about the new periodicity schedule in the training of medical and dental providers. Next slide, please.

The driving force for change in North Carolina was really the providers themselves. The DMA dental program fielded inquiries from leadership in pediatric dentistry and pediatric medicine about the need for a separate and distinct periodicity schedule that addressed the oral health needs of particularly young beneficiaries and gave more guidance regarding recommendations for the establishment of a dental home at a young age. Following its review of 16 states with low utilization of dental services in 2008, CMS became increasingly concerned about the need for updated periodicity schedules in all 50 states. Our federal partners helped to push the process forward in North Carolina by reminding us of their expectations for states relative to dental periodicity schedules. Next slide, please.

Great, so can we go to how the medical and dental providers responded to the new periodicity schedules? Were they supportive, or what was the reaction by your medical and dental providers?

This slide illustrates that prior to the adoption of the periodicity schedule, major changes were occurring in provider participation and the utilization of and the amount of expenditures made on pediatric oral health services in North Carolina Medicaid. So it would be fair to say that the implementation of the periodicity schedule reinforced a belief that had already been made apparent in the data over about a decade. In 2011, both dental and primary care of medical providers who participated Into the Mouths of Babes Program were fully engaged in promoting routine diagnostic and preventative care aimed at reducing the burden of disease in Medicaid enrolled infants and toddlers. As you will see in later slides, there are many

continuing education resources available to healthcare providers to keep them updated on the latest and greatest preventative techniques and preventative oral healthcare. Next slide, please.

Teamwork has been a key component to success in our battle against ECC in North Carolina. Having a diverse group of stakeholders engaged is proving to be the best recipe for success. It is the not good enough to restrict collaboration to the usual suspects of dental and medical provider groups. Integrating partnerships with funders, advocacy organizations, consumers, faith-based and religious groups, business, community, and civic organizations, and many other willing stakeholders goes a long way toward achieve better oral health for preschool children. Without going into great detail about the various collaborations targeting the prevention of early childhood caries that currently exists in our state, I will briefly mention a few.

First, the early childhood oral health collaborative is a broad stakeholder group that was the natural evolution of the Into the Mouths of Babes Operations Committee. It includes representatives of many organizations that have agreed that promoting best practices for optimal early childhood oral health is more complex than just slapping fluoride varnish on kids' teeth at a well visit. The group continues to take on important oral health topics, like the recommendation for fluoridated toothpaste for children under age two.

Next we have the Carolina Dental Home Project that was a HRSA-funded demonstration that piloted a homegrown risk assessment and referral guidelines tool in a small eastern North Carolina community. We worked with participating IMB primary care medical providers who helped refine the risk assessment tool. They refer children ages 6 to 42 months to a group of general dentists who receive special training in the initiatives and a pediatric dentist champion willing to accept referrals of children at moderate to high risk for early childhood caries. This was the first prototype for true integration of medicine and dentistry to meet the oral health needs of young at risk children in North Carolina.

Then we have the state's CHIP or grant project that had an oral health workgroup that developed opportunities to use the health navigation and provider training skills of quality improvement specialists. These QI specialists were important in helping the CHIP or oral health work group provide IMB training and disseminate report risk assessment and referral guidelines tools to a larger group of community care of North Carolina PCPs for further testing and refinement. Next slide, please.

And continuing, we had also the North Carolina Institute of Medicine who organized a task force to assist the Division of Medical Assistants in drafting its state oral health action plan in response to CMS's National Oral Health Initiative. The task force met from December 2012 through May 2013, bringing in many experts in oral health topics to discuss a variety of subjects pertinent to improving the delivery of services to publicly insured children.

The final report is a comprehensive blueprint, with findings and recommendations regarding strategies to improve the utilization of preventative oral health services for Medicaid and CHIP enrolled children. The link takes the reader to the webpage for the task force, which includes a wealth of information about its meetings in the final report.

The North Carolina Oral Health Collaborative is the state's newest broad-based coalition that recently developed a strategic plan, including short-term goals to reduce early childhood caries by promoting increased utilization of fluoride varnish and sealants. The collaborative also seeks to improve integration of medicine and dentistry and advance oral health literacy in our state. This collaborative includes many stakeholders that have not been traditionally included in oral health coalitions like business, consumer, agricultural, and faith-based organizations. These new partners bring a fresh new perspective to making a difference in oral health policy and programs.

And the state's newest dental school has an innovative model to educate its pre-doctoral and post-doctoral students, not only its flagship institution in Greenville, but also in eight different community service learning centers throughout North Carolina. ECU's mission is to bring new opportunities for improved oral health to the many citizens of North Carolina who do not reside in areas of the state with

large numbers of dental providers; thus, have limited access to care. The school recently graduated its first class of dental professionals, many of whom will join the dental workforce to serve the citizens of our state. Next slide, please.

The website for the “Into the Mouths of Babes/Connecting the Docs” toolkit is the go-to resource for primary care medical providers who would like to know more about how they can prevent early childhood caries in Medicaid enrolled infants and toddlers. It also gives them important information about support, risk assessment, and referral guidelines tools.

One of the exciting recent developments in oral health in North Carolina is that Blue Cross/Blue Shield and other commercial payers have been covering fluoride varnish applications in the medical office for their beneficiaries up to age five since January 1st, 2015. This is following the 2014 recommendation of U.S. Preventative Services Task Force. Blue Cross/Blue Shield of North Carolina modeled many of their ideas for coverage in the medical office after the Into the Mouths of Babes program. UNC's Baby Oral Health program is one of the premiere pediatric dental educational programs in the U.S. used in an array of media resources to train dental professionals to provide early and frequent routine oral care to very young children. Every graduate of UNC School of Dentistry leaves with a bOHP kit and the knowledge that they can be the dental home to help the infants and toddlers.

North Carolina is blessed to have some of the best and brightest minds in dentistry, medicine, and public health who are focused on the prevention and early childhood caries. North Carolina Department of Health and Human Services has, for a long time, reaped the benefits of its close proximity to these experts in their fields. Next slide, please.

With medical providers providing some of the dental services, how does Medicaid track preventive services and risk assessments and other services that may be provided by physicians and by dentists in your program?

Data collection reporting and analysis are vital to strategic planning for program initiatives aimed at reducing the impact of early childhood caries. The division of medical assistants has historically used paid claim status in a variety of ways to plan improvements in the delivery of service to our beneficiaries. This slide focuses on reports generated to demonstrate trends and beneficiary utilization of service, and where more can be done to increase access and hopefully improve oral health outcomes.

The state has a new Medicaid management information system, NC Track, which recently received CMS certification, a new database, NC Analytics, and a new reporting and analytics tool, Advantage Suite. We look forward to being able to put our claim status to higher and better use in future innovative oral health policy and program efforts. Next slide, please.

Many of our paid claims data reports focus on the extent of participation of our enrolled providers, both physicians in the Into the Mouths of Babes Program and dentists. We have consistently tracked the number of enrolled dental providers who are treating children in the zero to two and three to five age groups. Our data shows that more of our participating general dentists are treating preschool children than ever before. At the same time, we are experiencing growth in the number of primary care medical providers who are participating into the Into the Mouths of Babes Program. Access to oral health services for children under four years of age in North Carolina has never been better than it is now, and yet more needs to be done to ensure that all children are receiving preventive oral care and an early dental visit. Next slide, please.

It is best to think of oral health services rendered by primary care physicians to the Medicaid preschool beneficiary population as complementary and not duplicative. The past examinations of paid claim reports have shown that, for the most part, the children ages 6 to 42 months who are receiving oral health services from primary care physicians are children who are not able to access care in a dental office. There was very little overlap of services in the report searching for redundancy between diagnostic and preventative services performed in dental offices versus those rendered in medical offices. In its roll-out phase, Into the Mouths of Babes brought oral health care services to many counties, where a Medicaid

child under age three had never received a service in a dental office. Currently, almost 100,000 children, ages 6 to 42 months, receive an IMB visit each year. Next slide, please.

Thank you. In our last minute or two, can you just briefly describe communication that you've been trying to facilitate between a child's physician and a dentist to make this successful?

North Carolina sees the communication between physicians and dentists to be an area where more work needs to be done in the future. As one can tell from viewing the names of some of our initiatives, like Connecting the Docs, we see this as fertile ground for improving medical/dental integration. There's no doubt that NC Medicaid's primary care case management model Community Care Network North Carolina has been very successful in improving the quality and health outcomes, as well as controlling cost of care of the Medicaid population. The dental program has been a carve out from CCNC, and the North Carolina Medicaid program is in the middle of a legislative reform effort, which is examining different models of care. Prior to the latest reform efforts, there are were long-term plans to add dental providers to the CCNC fold. Dentists would have had access to innovative tools at a CCNC provider portal and would have been able to share information about beneficiary medical history and network quality metrics with their medical colleagues. Next slide, please.

Carolina Dental Home was really our first time dipping our toes in the water of medical and dental collaboration. This is the first time we held continuing education events between general dentists, who expressed a willingness to treat young kids, and pediatricians, so we could get the ice for them to talk to each other. We learned what did and did not motivate a primary care doctor to refer child at moderate to high risk for ECC. We also learned what role the dentist expected to play in the project. During the initiative, we discovered that in using our risk assessment and referral guidelines tool, about 20 to 30 percent of children in the 6 to 42-month age range were referred. The general dentists participating in the project were surprised there weren't more referrals of Medicaid enrolled children. As one can see, care coordination in the Carolina Dental Home was a problem that we acknowledge deserved more attention in future efforts. Next slide, please.

The North Carolina oral health collaborative and CCNC have focused their work on medical/dental integration pieces as well. They have held their own regional mixers, with physicians and dentists interested in improving the oral health of young children, along with the leadership from organized dentistry and medicine. CCNC is committed to improving the oral health status of young children and measures the effectiveness of its efforts to promote fluoride varnish application at well child visits and an early dental visit in all 14 of its networks.

Comparative data analysis across the CCNC networks is another way of measuring how well we are doing, and spreading the word that early childhood preventative oral health services are important for publicly insured young children. The future holds a lot of promise, but much is dependent on the vision for Medicaid reform in North Carolina. Once that vision is articulated by the executive and legislative branches of government, the Oral Health Policy Team that has always come together in North Carolina will once again rise to the challenge to find innovative ways to reduce the incidents and prevalence of early childhood oral disease in our state. Thank you so much. We're ready for the next slide.

Thank you so much to Darlene and Kelly, and everyone that has presented. If you have questions at this time, we've received numerous questions, so I'm going to start in on a couple of them. And unfortunately, we will not be able to get to all of them, but I do want to start with some of the questions that have come in already, but please send us more as we go. The question that I'm going to pose to Dr. Edelstein and to CMS both is a question that's come in a couple different iterations by talking about how these programs can be accomplished when many Medicaid and CHIP programs are dealing with very few providers on both the medical and dental side that will see Medicaid patients. So can you talk a little bit about how these programs can be accomplished when there's too few providers, based on low reimbursement rates, but how could this still be implemented given those barriers?

Thank you. Yes, a couple of things. Firstly, the providers who are already engaged are the best places to start with both expanding their own capacity, especially through partnering with other professionals. And

additionally, with their influencing their peers, because they've had the experience of working with Medicaid population in a way that has worked for them. And there has also been a temporal shift with the increased numbers of pediatric dentists, since we're talking about such young children. There's been an increased number of pediatric dentists trained, and there's been an increased, reported by the American Academy of pediatric dentistry, in the percentage of those pediatric dentists who not only accept patients, but the volume of patients they're accepting.

I think one way to approach this from the specific perspective of early childhood caries is to focus on the programs that deal with young children, so engaging dentists with Head Start, engaging dentists with early Head Start, with WIC, with early education programs. Dentists often have welcomed the opportunity to be engaged in their local communities, and one way to do that, then is to introduce the issues around early childhood caries through community organizations with which they can partner. Another is to link the safety net to private dentists.

There has been some success in contracting private dentists to augment the capacity of federally qualified health centers, and, again with a focus just on young children, that can work. Another way to approach dentists in the community is through their colleagues who are pediatricians. By and large, the volume of pediatricians, not only in raw numbers, but the percentage of pediatricians involved in caring for Medicaid populations, has been greater than for dentists, and so hearing from their peers in the medical community can be another way.

But, in essence, all of my recommendations relate to outreach, engagement, and raising the salience and the awareness of the local dentist just as we talk about raising the salience and the awareness of parent engagement on what they can do at home.

Great. Thank you, Dr. Edelstein. Does anybody want to add to his answer?

So Meg, this is Laurie Norris at CMS.

Great.

I'll add a couple of things. So we know that rates, reimbursement rates, are low in some states. I will remind our listeners that it is quite variable across the states. There are states that do have, you know, higher reimbursement rates and states that have lower reimbursement rates, but it is a state decision, and it's something that states can change, so if rates are really low in your state, that would be something that you might be able to influence in your state.

Also, I would just mention that rates are not the only reason that providers do or do not participate in Medicaid. There are other factors, such as how easy is it for them to sign up, what are the administrative barriers. Those sorts of things are also amenable to change. The amount of beneficiary support that the Medicaid agency providers can also help support providers to remain in the program if the beneficiaries are given the help they need to keep their appointments and get to their appointments, et cetera.

And then to echo what Dr. Edelstein said, it's not only dentists and physicians who can deliver the types of care we're talking about here, so it's always good to look at other provider types and other delivery settings that might work in your state.

Thank you, Laurie. To get to something you just alluded to with reimbursement rates, there's also a couple of questions regarding CMS's role and, potentially, sort of what is the flexibility of states when it comes to periodicity schedules and other areas. Can you talk a little bit about where CMS's role on things like periodicity schedules or things like who pays for fluoride varnish in some settings, versus what is the state's flexibility for some of those policies?

I think this would be a good question for Susan.

Sure. So essentially the federal statute says that states set their own periodicity schedules under advisement and consultation with medical and dental communities in their states. So setting the periodicity schedule is something that we look to the states to do. And while we encourage states to have the most up-to-date periodicity schedule possible, that's not something that we mandate, other than that they have one.

This is Meg again. Would that be true also of risk assessment? There were questions about risk assessment tools and which one CMS sees as the best risk assessment tools, if a state went down that path. Can you talk to state flexibility on those tools also?

Well I think for those kinds of tools, we would look for the medical and dental clinical communities to have an established risk assessment tool. I don't believe we endorse one. Laurie, is that something you can weigh in on?

That's correct, Susan. CMS does not endorse a particular risk assessment tool. That's something that a state could decide to pick one or to put a list together and say, as long as the provider uses one of these approved tools, it would be reimbursable, but that is definitely an area of flexibility for the states, as well as for who to pay to apply fluoride varnish.

As I mentioned, almost every state does reimburse physicians, and dental providers certainly, for that service, and states can also decide to allow other types of providers to do that service as well, as long as those providers are qualified to provide the service.

Great. So looking at some of the successes, can, Laurie, you talk a little bit, or, Susan, talk a little bit more about some of the reasons why we might see some variations across states, both from the medical and dental provider, and what we might be able to learn from what are considered the bright spots to improvement?

Well that's a story of our life here at CMS. You know, every state is different, and there is a huge variation across states in results and in approaches. And in terms of the approaches, that's certainly the way it should be. Every state is different, and every state has to figure out what will work for them. In terms of understanding why certain states may have been more successful than other states, that's been kind of a tough nut for us to crack. We don't really have resources to do evaluation studies of that sort of thing.

I don't know if, for example, in North Carolina, whether North Carolina has been able to do formal evaluations of Into the Mouths of Babes. I know there's been a lot of research published about that program. I don't know if Washington has funds to evaluate its ABCD program, but there's certainly room for more knowledge generation in that area to help us understand why certain things succeed and other things don't.

Great. Thank you, Laurie. Does anybody want to add to that? North Carolina, or Dr. Edelstein, any additional comments from learning from the Bright Spots.

Thanks, Meg, this is Mark Casey from North Carolina. I just want to say that, as Laurie referenced, there is a wealth of literature from UNC, the School of Public Health and the School of Dentistry, about Into the Mouth of Babes, so although our state agency hasn't published any research, UNC has, and there's a lot of good studies to support Into the Mouths of Babes and its effectiveness.

I would just add that in all three of the top-performing states there's been a concerted effort, well organized and managed by a team that has dug in and done the work to make this happen. So it's Into the Mouth of Babes in North Carolina. It's the ABCD program in Washington. It's the From the First Tooth effort in Maine. And I think what has happened in those states is the concerted engagement of multiple people to design and implement a careful plan to make these things happen, and I think there's a great deal that replicable across these programs for other states as well.

Great. Thank you so much for everyone's comments, and thank you for all the wonderful questions. We'll try to respond to some of these online also. But, Laurie, do you want to take it from here?

Yes. Thanks, Meg. Next slide, please.

So I just wanted to give you one last reminder about our three new issue briefs. We hope you download them, print them out, read them, hand them out, and use them in your work to move the ball forward for children's oral health. And please send us feedback as well. Next slide.

So that's all we have for you today, but as I said at the beginning, this is just the beginning of the conversation. We hope you stay tuned for more on this topic from CMS. We hope our presentations today have been stimulating for you, and we hope you have ideas for next steps you'd like to take in your state. You're looking at contact information for all of our presenters. Feel free to reach out to any one of us with questions, comments, and ideas, and we very much appreciate your joining us today. And thank you for all of your hard work to support children's oral health.

Now I'll turn the mic back to Brice to sign us off for the day, Brice.

This concludes the webcast for today. Please submit feedback to the presentation team using the survey in your browser window when the event concludes. If you are unable to provide your feedback at this time, you can view the on-demand recording of the event and access the survey widget there. The on-demand will be available approximately one day after the webcast and can be accessed using the same audience link that was sent to you following registration. Any future topics or discussion points can also be shared with the team using the Mac Quality TA at cms.hhs.gov mailbox. Thank you.