Bill as Introduced

HB 1537 - AS INTRODUCED

2010 SESSION

10-2718
05/10

HOUSE BILL *1537*

AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

SPONSORS: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill directs the department of health and human services to amend the Medicaid state plan to permit primary care providers to deliver preventive oral health services to children. The bill requires the providers to be certified before offering such services and makes the program contingent upon future funding.

This bill is a request of the study committee established in 2009, 130 (HB 414).

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

10-2718
05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 New Section; Department of Health and Human Services; Children's Oral Health Initiative.
2 Amend RSA 126-A by inserting after section 4-f the following new section:
3 126-A:4-g Children's Oral Health Initiative.
4 I. On or before January 1, 2011, the department of health and human services shall submit
5 a Title XIX Medicaid state plan amendment to the Centers for Medicare and Medicaid Services for
6 the purpose of establishing the children's oral health initiative. The amendment shall authorize
7 primary care providers to deliver preventative oral health services, such as dental screenings and
8 fluoride varnish treatments, to children under the state Medicaid program. Primary care providers
9 who choose to participate in the program shall complete training approved by the department and
10 submit evidence of program completion to the New Hampshire Medical Society, which shall
11 maintain, and make available to the department, a list of certified providers.
12 II. The commissioner of the department of health and human services shall adopt rules
13 under RSA 541-A relative to administration of the children's oral health initiative, including
14 eligibility criteria, the type and frequency of services covered, reimbursement rates, and provider
15 certification requirements. The department also shall develop a list of approved training programs,
16 which shall include, but may not be limited to, those offered by the American Academy of Pediatrics
17 and the Southern New Hampshire Area Health Education Center.
18 III. The department shall seek funding for the program as part of the department's budget
19 for the biennium ending June 30, 2013, and each biennium thereafter. Program implementation
20 shall be contingent upon sufficient funding and approval of the state plan amendment required
21 under this section.
22 2 Effective Date. This act shall take effect 60 days after its passage.

LBAO
10-2718
02/01/10

HB 1537 FISCAL NOTE

AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

FISCAL IMPACT:

The Department of Health and Human Services states this bill will have no fiscal impact in FY 2011. This bill may increase state expenditures by an indeterminable amount in FY 2012 and each year thereafter. This bill will have no fiscal impact on state, county, and local revenue or county and local expenditures.

METHODOLOGY:

The Department of Health and Human Services (DHHS) states this bill directs the Department to submit a Title XIX Medicaid state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS), on or before January 1, 2011, authorizing primary care providers to deliver preventative oral health services, such as dental screenings and fluoride varnish treatments, to children under the state Medicaid program. Primary care providers (PCP's) who choose to participate in the program would be required to complete training approved by the Department and submit evidence of program completion to the New Hampshire Medical Society, which shall maintain, and make available to the department, a list of certified providers. The bill also requires the Department to seek funding for the program as part of the Department's budget for the biennium ending June 30, 2013, and each biennium thereafter. Program implementation would be contingent upon sufficient funding and approval of the state plan amendment by CMS. The Department states they will need to make modifications to the Claims Payment System to add this benefit to the menu of reimbursable claims, as well as complete State plan amendment and rules. The Department states since DHHS would have to prepare a budget, irrespective of the passage of this bill, the bill itself would have no fiscal impact.

In the event that the proposed program is implemented, the Department has provided a high-level and upper-end cost estimate of the program. The Department states there are approximately 20,000 children, age 0-3 on Medicaid at any given time receiving well child checks. For the purposes of this fiscal note, DHHS assumes all such children will receive the service making this estimate a maximum exposure projection. The Department states at least

two annual applications of fluoride varnish are necessary to ensure efficacy. Each service would consist of oral health risk assessment, application of fluoride varnish, provision of anticipatory guidance to caregiver and referral with follow-up to a participating dentist. These services would be reimbursed at $38.00 per encounter, resulting in a cost of approximately $1,520,000 (20,000 children X $38 per encounter X 2 annual applications).

The Department states that only 75% of children receiving the primary care oral health intervention will ultimately engage with a dentist either because the child already has a dental home or because the family simply does not follow up. Children who are seen by a dentist following the referral by the PCP will receive at a minimum a comprehensive oral evaluation. Evaluations would be reimbursed at $54.50 per visit, resulting in a cost of approximately $817,500 annually (15,000 children X $54.50).

In total, the proposed bill could have a maximum impact of approximately $2,337,500 ($1,520,000 + $817,500), of which 50% or $1,168,750 would be state general funds. The Department states they would anticipate that application of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, to the preventative oral health services identified in this bill would have an indeterminable downstream savings. The exact fiscal impact cannot be determined at this time.

The Office of Legislative Budget Assistant states this bill was a request of the Commission to Study Preventing Dental Disease among New Hampshire's Children which was established pursuant to Chapter 130:2. Laws of 2009. The final report of the Commission issued November 1, 2009 includes the following information –

- The New Hampshire Medicaid Program paid $641,915 in claims in CY 2007 and $738,196 for CY 2008 for outpatient operating room services associated with preventable dental conditions in young children. This represented 436 and 574 patients, respectively;

- The NH Medicaid Program reports that in CY 2008, 312 children (0-18 years) enrolled in NH Medicaid were seen in the emergency department of various hospitals for dental conditions. Of these 110, had at least one dental office visit in 2007;

- Under the EPSDT benefit for children in the Medicaid program, dental services must be provided at regular intervals that meet the reasonable standards set by each state. EPSDT covers any and all services that are determined to be medically necessary.

The Office of Legislative Budget Assistant has prepared this fiscal note in accordance with RSA 14:46, V.

Amendments

"NOT ADOPTED"

Rep. DiPentima, Rock. 16
January 7, 2010
2010-0104h
05/10

Amendment to HB 1537

1 Amend the title of the bill by replacing it with the following:

2

3 AN ACT allowing primary care providers to provide preventive oral health services to
4 children between 0 and 3 years of age under the state Medicaid program.

5

6 Amend the bill by replacing 126-A:4-g as inserted by section 1 of the bill with the following:

7

8 126-A:4-g Children's Oral Health Initiative.

9 I. On or before January 1, 2011, the department of health and human services shall submit
10 a Title XIX Medicaid state plan amendment to the Centers for Medicare and Medicaid Services for
11 the purpose of establishing the children's oral health initiative. The amendment shall authorize
12 primary care providers to deliver preventative oral health services, such as dental screenings and
13 fluoride varnish treatments, to children between 0 and 3 years of age under the state Medicaid
14 program. Primary care providers who choose to participate in the program shall complete training
15 approved by the department and submit evidence of program completion to the department, which
16 shall maintain a list of trained providers.

17 II. The commissioner of the department of health and human services shall adopt rules
18 under RSA 541-A relative to administration of the children's oral health initiative, including
19 eligibility criteria, the type and frequency of services covered, reimbursement rates, and provider
20 training requirements. The department also shall develop a list of approved training programs,
21 which shall include, but may not be limited to, those offered by the American Academy of Pediatrics
22 and the Southern New Hampshire Area Health Education Center.

23 III. The department shall seek funding for the program as part of the department's budget
24 for the biennium ending June 30, 2013, and each biennium thereafter. Program implementation
25 shall be contingent upon sufficient funding and approval of the state plan amendment required
26 under this section. Upon implementation of the program, the department shall provide a list of
27 dentists participating in the state Medicaid program to primary care providers upon request.

2010-0104h

AMENDED ANALYSIS

This bill directs the department of health and human services to amend the Medicaid state plan to permit primary care providers to deliver preventive oral health services to children between 0 and 3 years of age. The bill requires the providers to complete certain training before offering such services and makes the program contingent upon future funding.

This bill is a request of the study committee established in 2009, 130 (HB 414).

Rep. Miller, Belk. 3
January 21, 2010
2010-0232h
05/03

Amendment to HB 1537

1 Amend the title of the bill by replacing it with the following:
2
3 AN ACT allowing primary care providers to provide preventive oral health services to
4 children between 0 and 3 years of age under the state Medicaid program.
5
6 Amend RSA 126-A:4-g as inserted by section 1 of the bill by replacing it with the following:
7
8 126-A:4-g Children's Oral Health Initiative.
9 I. The department shall seek funding for a Medicaid children's oral health initiative
10 program as part of the department's budget for the biennium ending June 30, 2013, and each
11 biennium thereafter. The program shall provide reimbursement to primary care providers who
12 deliver preventative oral health services, such as dental screenings and fluoride varnish treatments,
13 to children between 0 and 3 years of age enrolled in the state Medicaid program. Primary care
14 providers who choose to participate in the program shall complete training approved by the
15 department and submit evidence of program completion to the department, which shall maintain a
16 list of trained providers. Program implementation, including adoption of rules required by
17 paragraph II, and submission of a Medicaid state plan amendment as required by paragraph III,
18 shall be contingent upon sufficient funding.
19 II. The commissioner shall adopt rules under RSA 541-A relative to administration of the
20 children's oral health initiative, including eligibility criteria, the type and frequency of services
21 covered, reimbursement rates, and provider training requirements. The department also shall
22 develop a list of approved training programs, which shall include, but may not be limited to, those
23 offered by the American Academy of Pediatrics and the Southern New Hampshire Area Health
24 Education Center. Upon implementation of the program, the department shall provide, upon
25 request, a list of dentists participating in the state Medicaid program to primary care providers in
26 the oral health initiative.
27 III. The department shall submit a Title XIX Medicaid state plan amendment to the Centers
28 for Medicare and Medicaid Services for the purpose of establishing the children's oral health
29 initiative.

2010-0232h

AMENDED ANALYSIS

This bill directs the department of health and human services to seek funding for a children's oral health initiative that would enable primary care providers to deliver preventive oral health services to children between 0 and 3 years of age under Medicaid. The program is contingent upon future funding and approval of a state Medicaid plan amendment.

Committee Minutes

HOUSE COMMITTEE ON FINANCE

WORK SESSION ON HB 1537

BILL TITLE: (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

DATE: February 16, 2010

LOB ROOM: 210-211 Time Work Session Called to Order: 11:15

Time Adjourned: 12:00

(please circle if present)

Committee Members: Reps. M. Smith, Nordgren, ~~Foster, Eaton~~, Baroody, Benn, Leishman, DeJoie, Buco, Foose, Mitchell, Keans, Casey, Harris, Kurk, ~~D. Scamman~~, E. Anderson, Emerton, Rodeschin, Wendelboe, L. Ober, Dokmo, Bergin, Belvin and R. Elliott.

Bill Sponsors: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Mr. Michael Kane, Legislative Budget Assistant (LBA): Makes effective in 2012, 2013. Amended fiscal note.

Rep. Kurk: Why not use airport technique? Get in budget this year without money then ask for more in next biennium.

Atty. Lisabritt Solsky, representing Department of Health and Human Services (DHHS): Bill originally passed had no fiscal impact. As bill considered by policy fiscal note requested. Would value connection with dental. Reviewed prepared testimony. Will support if funded.

Rep. Kurk: New program would cost $1,200,000. We would save $800,000 that we're spending.

Atty. Solsky: Program would link child with a dental home. Makes breakeven hard to calculate.

Rep. Kurk: We won't get our $1.2 million back. We'll only save $800.

Atty. Solsky: We'll get money back over time.

Rep. Wendelboe: There is a dental shortage already. Are there going to be dentists?

Atty. Solsky: We have a shortage of dentists in NH.

Rep. Wendelboe: Poor public education or use of bottles.

Atty. Solsky: Lots of work has been done.

Rep. Wendelboe: Don't primary care doctors look in mouth?

Atty. Solsky: Doctors looking at throat not teeth. Doctors not focusing on decay.

Rep. Wendelboe: How much of $38 would be paid for coating? Could coating be too much?

Atty. Solsky: $38 includes four components. More activity than with dentists. Doctors will apply floride varnish.

Rep. Emerton: Status of Hopkinton lawsuit?

Atty. Solsky: Allegations filed 2 weeks ago. We have been litigating for 10 years. We have made progress.

Rep. Emerton: If you lose what will happen?

Atty. Solsky: We'd still be under court supervision.

Rep. Kurk: Why would department want to expand safety net when funds are scarce?

Atty. Solsky: Delicate balance. We support prevention. Costs won't hit until 2011.

Rep. Elliott: Why 0-3? Babies don't have teeth.

Atty. Solsky: Recommendation for dental screening of 6 months by professional society.

Vice Chairman Nordgren: Pediatricians can initiate discussion at 6 months.

Rep. Kurk: Do we provide dental care on teeth that will fall out?

Atty. Solsky: Infection can bridge from 1st set to 2nd set (of teeth). We provide dental benefits at any age.

Rep. Kurk: What services do we provide now?

Atty. Solsky: Preventative, restorative, comprehensive.

Rep. Kurk: Would you provide description of dental benefits?

Atty. Solsky: Easy to provide.

Rep. Harris: Shortage of primary care physicians. Are they interested?

Atty. Solsky: Yes.

Rep. DeJoie: Bill doesn't expand services, just expands network of providers?

Atty. Solsky: Yes.

Rep. DeJoie: If kids don't receive care is there long term impact?

Atty. Solsky: I've done this earlier but there are solutions.

* **Rep. DePentima**, Pime sponsor: Zero to 3 don't have teeth, by 1 most have teeth. Twenty pediatric dentists in NH. General dentists not training to take care of children. We should look at what we spend and spend it wisely. (Described written testimony.) Done in 36 other states even with economic pressures. Reviewed his cost benefit analysis. Dental illness is most common preventable disease for children. #1 recommendation of commission that studied the subject.

Rep. Kurk: Thoughtful numbers. No provider or patient required to participate. Is self selection going to reduce impact?

Rep. DiPentima: No this is Medicaid.

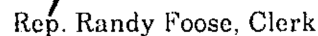
Rep. Leishman: 21,000 kids not getting dental care; are these all poor children? Why so many kids?

Rep. DiPentima: We're learning more about dental issues.

Rep. D. Scamman: Your savings come from avoiding operations. Can't pediatricians be encouraged to do their job better?

Work session adjourned.

Respectfully submitted,



Rep. Randy Foose, Clerk

HOUSE COMMITTEE ON FINANCE

WORK SESSION ON HB 1537

BILL TITLE: (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

DATE: February 18, 2010

LOB ROOM: 210-211 Time Work Session Called to Order: 11:15

Time Adjourned: 12:00

(please circle if present)

Committee Members: Reps. M. Smith, Nordgren, Foster, Eaton, Baroody, Benn, Keishman, DeJoie, Buco, Foose, Mitchell, Keans, Casey, Harris, Kurk, D. Scamman, E. Anderson, Emerton, Rodeschin, Wendelboe, L. Ober, Dokmo, Bergin, Belvin and R. Elliott.

Bill Sponsors: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

1 Kane
(2) Solsky
(3) D. Pedimonte

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

Kane - makes ~~effective~~ in 2012, 2013
amended fiscal note come

Kurk - why not use Airport technique -
Get in budget this year w/o money
then ask for more in next biennium

Sulsky - Bill originally passed had no
fiscal impact
As bill considered by policy fiscal
note requested
Would value connection w/dental
Reviewed prepared testimony
Will support if funded

Kurk New program would cost $1,200,000
We would save $800,000 that we're spending

Solsky - Program would link child with a dental
home - Makes breakeven hard to calculate

Kurk We won't get our $1,2 mil back
~~An~~ You'll only save $800

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We'll get $ back over time

Weddleboe
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Wendlebae - don't primary care docs look in mouth

Solsky - docs looking at throat not teeth. docs not focusing on decay

Wendlebae - How much of $38 would be paid for coating ~~Be~~ could coating be too much.

Solsky - $38 includes four components ~~xxx~~ More activity than w/dentists Doctor will apply floride varnish

Emerton
Status of Hopkins lawsuit

Solsky
- Allegations filed 2 weeks ago We have been litigating for 10 years We have make progress

Emerton -
- If you lose what will happen

Solsky - we'd still be under court supervision

Kurk - Why would dept want to expand safety net when funds are scarce

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Elliott - Why 0-3. babies don't have teeth

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Solsky
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Kurk

What services do we provide now

Solsky

Preventative & Restorative comprehensive

Kurk

Would you provide description of dental benefits

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Easy to provide

Harris

Shortage of primary care physicians
Are they interested

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Bill doesn't expand services Just expand
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DePatimo

0-3 don't have teeth by 1 most have teeth
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No provider or patient required to participate
~~Will saving~~ Is self selection going to reduce impact

Dr Pedim - No this is medicaid

Kirschman - 20,000 kids not getting dental care Are these all poor children why so many kids

Dr Petima - We're learning more about ~~dentistry~~ dental issues

Scamman -
Your savings come from avoiding operating
Can't pediatricians be encouraged to do their job better

(2)

HB 1537
February 16, 2010 Talking Points
House Finance Committee
Lisabritt Solsky, Esq.
Deputy Medicaid Director
NH Department of Health and Human Services

- We understand the Department's responsibilities under this bill to be threefold: to create a primary care oral health project to be funded by the legislature in the Department's 2012-2013 biennial budget, to adopt administrative rules detailing the implementation of such a program and to submit a Medicaid State Plan Amendment to that effect in order to receive federal approval for matching funds.

- The Department can fulfill these responsibilities.

- As a matter of policy, the Department sees the value in engaging primary care providers as one tool in our efforts to unite all children enrolled in Medicaid with a Dental Home where s/he receives all necessary preventative and restorative oral health care would assist the Department in fulfilling its oral health requirements under Early and Periodic Screening Diagnostic and Treatment regulations.

- From a fiscal perspective we know that between CFY 2007 and CFY 2008, the NH Medicaid program paid $1.6M total funds (or $800,000 general funds) in claims to dentists to provide dental care within the outpatient or ambulatory surgical setting. We also know that 99% of the dental-related operating room costs are for the 0-3 year age group.

- We understand that many other states have implemented the benefit contemplated by the proposal before you today and have attested to its efficacy in reducing dental disease in children and therefore by connection, those costs related to dental services provided in an operating room setting.

- The Department expects as with any new initiative, that there will be a slow ramp up in the utilization of the service. We also know that this preventive benefit requires some level of up front investment with the reasonable hope for a reduction in expenditures in the not too distant future after implementation.

- Thus we find ourselves in a difficult position – we have a significant budget shortfall and technically should not be taking any action that exacerbates that shortfall further and yet, we have a prevention-based initiative that in the long run shows credible promise to create savings in provider payments as well as improve the health of children. Accordingly, consistent with the intent of the bill DHHS will propose this program for funding in our 2012/2013 agency budget request and assuming our request is granted, we stand ready to implement this initiative.

(3)

HB 1537 TESTIMONY

FINANCE COMMITTEE

February 16, 2010

Good morning/afternoon Madam Chair and members of the Finance Committee. For the record, I am Rep. Rich DiPentima representing Rockingham 16 (Portsmouth and Newington) I am a member of the Health, Human Services and Elderly Affairs Committee and Prime sponsor of HB 1537. I apologize in advance for the length of my testimony, but the circumstances require this depth of explanation. HB 1537 is legislation that was recommended by a Study Commission established last year as a result of the passing of HB 414. The Commission was charged to study preventing dental disease among NH children, and our report was submitted to the appropriate parties on Nov 1, 2009. This bill directs the DHHS to amend the State Medicaid Plan to allow reimbursement to appropriately trained primary medical care providers who perform oral screenings and preventive services on Medicaid children age 0-3 years old. This policy is currently in effect in 36 states including every other New England State. The policy issues related to HB 1537 have already been settled as evidenced by a very active public hearing where no opposition to the bill was received and supporters included Dr. Susan Lynch and the 18-0 vote by the H, HS&EA Committee. Today I am here to address the fiscal issues involving HB 1537.

The fiscal note that was prepared for HB 1537 is, in my opinion and the opinion of experts severely flawed. However, I actually wish that this fiscal note was totally accurate and possible to achieve. If it were so, it would represent one of the greatest public health achievements of any state in history. If it were accurate, it would also result in a 10 fold increase in the projected savings of this program which I will discuss shortly. But as with so many things that are too good to be true, such is the case with this fiscal note. Please allow me to discuss the various flaws in the methodology and conclusions contained in this FN, as well as inconsistencies in data provided by the Department.

1.. In October 2009, the Commission received a letter from DHHS stating that "To implement this benefit expansion statewide for the 20,500 children age 0-3years, the estimated fiscal impact is $350,00 general funds." While I disagreed with this estimate, I find it interesting that in less than three months the maximum impact has increased to $1,168,750 in general funds. This represents quite a discrepancy from the earlier estimate and causes me to question the Department's credibility.

2. The current FN, which I acknowledge is high-level and upper-end cost estimate, does not consider the experience of any of the other 36 states currently providing this benefit. The Department assumes that all 20,000 children age 0-3 on Medicaid will receive the services provided through the expanded benefit. This assumption is totally unrealistic and is inconsistent with the experience of all 36 states that provide this benefit. We have contacted a number of the states and inquired about the number of eligible children that actually received this benefit in the first year. Our analysis shows that on average, less than 10% actually received this benefit, and none have yet achieved 100% participation. The reason for such a low participation is due to factors associated with having primary care providers trained to provide the service and gaining the acceptance of primary care providers to add this to their current practice. The experience in all the other 36 states indicates that this is a slow process that will take many years to achieve full participation. For example, Maine which initiated the program a few years ago had 1,948 eligible children receive this benefit from January 2008-March 1, 2009. There is no reason to believe that New Hampshire's experience would be significantly different from all of the other 36 states.

3. While not contained in the FN, you may hear from the Department that the reason for the above estimate is based on Federal law, specifically 42 USC. The Department provided a document to the Sub-Committee of H, HS&EA working on HB 1537 stating that this law would require "that all PCPs performing well child checks be trained to ensure that comparable access is assured to all eligible children." In none of the 36 other states have all PCPs been required to be trained before providing the benefit to eligible children receiving the services from PCPs that have been trained. In order to support my position, I have checked with two legal sources very familiar with 42 USC and they both agree that it does not require all PCPs to be trained before providing the benefit. Information for a MN physician who is familiar with this program did an inquiry on this matter with a colleague in the EPSTD Program. He reports that with regard to 42 USC and other states requiring 100% of physicians be trained before any could be reimbursed "No, we do not, nor have ever heard any other state who does, construe that section to mean anything like that, on Fluoride Varnish or any other topic or aspect of screening." The National Academy for State Health Policy, 42 USC refers to compatibility. What compatibility means is that if you decide to cover fluoride varnish that you have to be willing to pay for it when it is provided by any qualified provider to any Medicaid-covered child in the state. But, you do not have to make sure that there are any number of PCP's who are qualified, nor do you have to make sure that there is one in every county. As such the estimate that 100% of eligible children (20,000) will receive this benefit is based on a totally false assumption and grossly overestimates the fiscal impact of this legislation by about 90% with regard to the $1,520,000 stated in the paragraph two of the methodology contained in the FN.

4. In paragraph 4 of the FN methodology it estimates that 75% of the 20,000 children will "ultimately engage with a dentist" resulting in an additional cost of $817,500 in general funds annually. Considering points 2 and 3 above the estimate that 15,000 children will engage with a dentist is totally unrealistic and physically impossible, and in fact, even if it were possible, is something that could happen today without this legislation. There is nothing that currently prevents PCPs from referring these children to dentists today. Considering that almost all Medicaid children age 0-3 see a PCP 9-15 times in their first years of life, and often have their mouth examined, if the PCP notices dental disease they are free to make a dental referral. As such, the Department should already have budgeted the $817,500 since this potential expenditure already exists and is not something that would result from this legislation.

However, more importantly, there is not sufficient dental manpower in NH to absorb the 15,000 children the Department claims will "engage with a dentist." There are only 24 pediatric dentists in NH and all of them have practices that are already at maximum. There are currently 926 dentists in NH 787 who are general dentists. Of the total dentists, 625 are enrolled in Medicaid but only 397 actually billed Medicaid in 2009. Furthermore, of those general dentists who do see Medicaid children, very few will see children age 0-3. The reason for this is that they are not trained to work on children this young and are justifiably uncomfortable treating these children. In NH, of the approximately 21,000 children age 0-3 on Medicaid, approximately 2,800 have actually seen a dentist. While I truly wish that 15,000 Medicaid children would "engage with dentist" this is unfortunately an impossible scenario and the fiscal Committee should disregard this cost estimate. The dental capacity to achieve such an estimate simply does not exist in NH. I will provide a more realistic estimate in my cost analysis shortly.

5. The FN fails to consider any potential savings to the State's General Fund as a result of this expanded benefit. In 2007 and 2008 combined, 983 children were treated in hospital operating rooms for removal of some or all of their severely decayed teeth. Of these, 519 were age 0-4. In these two years combined, the state paid out $3 million, of which $1.5 million was state general funds for removal of decayed teeth on young children, a condition that is almost 100% preventable. In CY 2008, 312 children enrolled in Medicaid were seen in Emergency Room for dental conditions. The Department did not provide the costs associated with these visits, which are almost 100 % preventable. The department reports that 99% of the dental-related OR and ED costs for children age 0-3 are for dental caries, which can be reduced by 38% with fluoride varnish applications by PCP's .

6. The State was successfully sued in Federal Court by a group of Medicaid clients regarding lack of access to dental care in 1999 (Hawkins v. Commissioner DHHS). The Department entered into a Consent Decree with the plaintiffs in January 2004 agreeing to improve access to dental care for this class of clients. In 2008 the plaintiffs filed a motion to hold the DHHS in contempt

of court for failing to comply with the Consent Decree. This motion was rejected by the court without prejudice. The plaintiffs have again filed a motion on January 21, 2010 to hold DHHS in contempt of court for violations of the Consent Decree. In the Defendant's Memorandum of Law filed with this motion they list a number of actions the Defendant had and has the ability to perform to comply with the court-ordered Decree. Among those actions the Department had and has the ability to do is to pay physicians to perform various services for their pediatric patients who are Hawkins class members. Prevention of early childhood caries and fluoride supplementation are two of the services referred to. In discussions with the attorney representing the Hawkins class members she stated that HB 1537 is in a parallel course with the Hawkins Case. As such, implementing the benefit provided by HB 1537 would at least partially improve the Departments compliance with the court-ordered Consent Decree.

Lastly, please allow me to present my estimate of the potential costs/benefits that would result from adoption of HB 1537.

For the reasons stated, I request that the Committee either accept my reality based fiscal analysis and vote ought to pass on HB 1537 or reject the FN attached to HB 1537 and request that the LBA and the Department amend their methodology and assessment to reflect real world experience with this benefit and the potential savings that will be derived from the preventive services provided through this legislation. To do otherwise, will condemn hundreds of poor children to unnecessary pain and suffering for the foreseeable future and continue to waste taxpayer's money paying for preventable treatments.

I thank the committee for your patience and allowing me the opportunity to present my case. I am happy to answer any questions you may have.

Estimated Cost Savings From Implementation of HB 1537

Primary Care Medical Reimbursement	Procedure Code	Proposed Fee	#Services/year	Cost/year
Oral Health Assessment and Survey	120/145			
Fluoride Varnish Application	1203/1206	$30	2	$60

Fiscal Impact/Savings

	FY 2012	FY 2013
Projected initial participation and % increase/year	10%*	15%
Number of children receiving prevention	2,172	2,498
Cost/child/year	$60	$60
Expenses Total	$130,320	$149,800
State	$65,160	$74,940
Federal	$65,160	$74,940
Savings		
Projected OR days avoided	25	50
Estimated savings from reduced OR use+	$80,000	$120,000
State	$40,000	$60,000
Federal	$40,000	$60,000

Number of children projected to have cavities 40%**	868	911
Restoration cost (2 cavities/child@$150/child)	$130,200	$136,650
Dental care avoided at 38% reduction rate* **	**$49,476**	**$51,927**
Total net Savings including OR	**$129,476**	**$171,927**
State	**$64,738**	**$85,964**
Federal	**$64,738**	**$85,963**
Total Savings /costs after costs of program	**($844)**	**$7,773**
State	**($422)**	**$3,887**
Federal	**($422)**	**$3,886**

*Based on the number of children receiving benefit in NC and ME in first year

**Based on Head Start and 3rd grade surveys of children in NH

***Based on published data of the effectiveness of fluoride varnish in reducing dental decay when done in a PCP office.

+Based on charge data provided by DHHS @ $3,200 per case.

10Feb2010... 0232h

2010 SESSION

10-2718
05/10

HOUSE BILL *1537*

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

SPONSORS: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill directs the department of health and human services to seek funding for a children's oral health initiative that would enable primary care providers to deliver preventive oral health services to children between 0 and 3 years of age under Medicaid. The program is contingent upon future funding and approval of a state Medicaid plan amendment.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 1537 – AS AMENDED BY THE HOUSE

10Feb2010... 0232h

10-2718
05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 New Section; Department of Health and Human Services; Children's Oral Health Initiative.
2 Amend RSA 126-A by inserting after section 4-f the following new section:
3 126-A:4-g Children's Oral Health Initiative.
4 I. The department shall seek funding for a Medicaid children's oral health initiative
5 program as part of the department's budget for the biennium ending June 30, 2013, and each
6 biennium thereafter. The program shall provide reimbursement to primary care providers who
7 deliver preventative oral health services, such as dental screenings and fluoride varnish treatments,
8 to children between 0 and 3 years of age enrolled in the state Medicaid program. Primary care
9 providers who choose to participate in the program shall complete training approved by the
10 department and submit evidence of program completion to the department, which shall maintain a
11 list of trained providers. Program implementation, including adoption of rules required by
12 paragraph II, and submission of a Medicaid state plan amendment as required by paragraph III,
13 shall be contingent upon sufficient funding.
14 II. The commissioner shall adopt rules under RSA 541-A relative to administration of the
15 children's oral health initiative, including eligibility criteria, the type and frequency of services
16 covered, reimbursement rates, and provider training requirements. The department also shall
17 develop a list of approved training programs, which shall include, but may not be limited to, those
18 offered by the American Academy of Pediatrics and the Southern New Hampshire Area Health
19 Education Center. Upon implementation of the program, the department shall provide, upon
20 request, a list of dentists participating in the state Medicaid program to primary care providers in
21 the oral health initiative.
22 III. The department shall submit a Title XIX Medicaid state plan amendment to the Centers
23 for Medicare and Medicaid Services for the purpose of establishing the children's oral health
24 initiative.
25 2 Effective Date. This act shall take effect 60 days after its passage.

LBAO
10-2718
02/01/10

HB 1537 FISCAL NOTE

AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

FISCAL IMPACT:

The Department of Health and Human Services states this bill will have no fiscal impact in FY 2011. This bill may increase state expenditures by an indeterminable amount in FY 2012 and each year thereafter. This bill will have no fiscal impact on state, county, and local revenue or county and local expenditures.

METHODOLOGY:

The Department of Health and Human Services (DHHS) states this bill directs the Department to submit a Title XIX Medicaid state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS), on or before January 1, 2011, authorizing primary care providers to deliver preventative oral health services, such as dental screenings and fluoride varnish treatments, to children under the state Medicaid program. Primary care providers (PCP's) who choose to participate in the program would be required to complete training approved by the Department and submit evidence of program completion to the New Hampshire Medical Society, which shall maintain, and make available to the department, a list of certified providers. The bill also requires the Department to seek funding for the program as part of the Department's budget for the biennium ending June 30, 2013, and each biennium thereafter. Program implementation would be contingent upon sufficient funding and approval of the state plan amendment by CMS. The Department states they will need to make modifications to the Claims Payment System to add this benefit to the menu of reimbursable claims, as well as complete State plan amendment and rules. The Department states since DHHS would have to prepare a budget, irrespective of the passage of this bill, the bill itself would have no fiscal impact.

In the event that the proposed program is implemented, the Department has provided a high-level and upper-end cost estimate of the program. The Department states there are approximately 20,000 children, age 0-3 on Medicaid at any given time receiving well child checks. For the purposes of this fiscal note, DHHS assumes all such children will receive the service making this estimate a maximum exposure projection. The Department states at least

two annual applications of fluoride varnish are necessary to ensure efficacy. Each service would consist of oral health risk assessment, application of fluoride varnish, provision of anticipatory guidance to caregiver and referral with follow-up to a participating dentist. These services would be reimbursed at $38.00 per encounter, resulting in a cost of approximately $1,520,000 (20,000 children X $38 per encounter X 2 annual applications).

The Department states that only 75% of children receiving the primary care oral health intervention will ultimately engage with a dentist either because the child already has a dental home or because the family simply does not follow up. Children who are seen by a dentist following the referral by the PCP will receive at a minimum a comprehensive oral evaluation. Evaluations would be reimbursed at $54.50 per visit, resulting in a cost of approximately $817,500 annually (15,000 children X $54.50).

In total, the proposed bill could have a maximum impact of approximately $2,337,500 ($1,520,000 + $817,500), of which 50% or $1,168,750 would be state general funds. The Department states they would anticipate that application of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, to the preventative oral health services identified in this bill would have an indeterminable downstream savings. The exact fiscal impact cannot be determined at this time.

The Office of Legislative Budget Assistant states this bill was a request of the Commission to Study Preventing Dental Disease among New Hampshire's Children which was established pursuant to Chapter 130:2. Laws of 2009. The final report of the Commission issued November 1, 2009 includes the following information –

- The New Hampshire Medicaid Program paid $641,915 in claims in CY 2007 and $738,196 for CY 2008 for outpatient operating room services associated with preventable dental conditions in young children. This represented 436 and 574 patients, respectively;

- The NH Medicaid Program reports that in CY 2008, 312 children (0-18 years) enrolled in NH Medicaid were seen in the emergency department of various hospitals for dental conditions. Of these 110, had at least one dental office visit in 2007;

- Under the EPSDT benefit for children in the Medicaid program, dental services must be provided at regular intervals that meet the reasonable standards set by each state. EPSDT covers any and all services that are determined to be medically necessary.

The Office of Legislative Budget Assistant has prepared this fiscal note in accordance with RSA 14:46, V.

LBAO
10-2718
Amended 02/17/10

HB 1537 FISCAL NOTE

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

FISCAL IMPACT:

The Department of Health and Human Services states this bill, **as amended by the House (Amendment #2010-0232h)**, will have no fiscal impact in FY 2011. This bill may have an indeterminable impact on state expenditures in FY 2012 and each year thereafter. This bill will have no fiscal impact on state, county, and local revenue or county and local expenditures.

METHODOLOGY:

The Department of Health and Human Services (DHHS) states this bill directs the Department to include a Medicaid benefit expansion for preventative oral health services in its agency budget request for the biennium ending June 30, 2013, and each biennium thereafter. The Department would be required to adopt rules and submit a Title XIX Medicaid state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) if sufficient funding is provided to the Department in the State's FY 2012-2013 operating budget. Implementation of the program would be contingent on sufficient funding and approval of the state plan amendment by CMS. The Department states the proposed bill would have no fiscal impact as it would only require the Department to seek funding for the program and require implementation if sufficient funding is granted.

For informational purposes, the Department states –

- There are approximately 20,000 children, age 0-3 on Medicaid at any given time receiving well child checks.
- At least two annual applications of fluoride varnish are necessary to ensure efficacy. Each service would consist of oral health risk assessment, application of fluoride varnish, provision of anticipatory guidance to caregiver and referral with follow-up to a participating dentist. These services would be reimbursed at $38.00 per encounter.
- Only 75% of children receiving the primary care oral health intervention will ultimately engage with a dentist either because the child already has a dental home or because the family simply does not follow up. Children who are seen by a dentist following the referral by the primary care physician will receive at a minimum a comprehensive oral evaluation. Evaluations would be reimbursed at $54.50 per visit.
- Claims Payment System modification will be necessary to add this benefit to the menu of reimbursable claims.

- It is anticipated that the application of fluoride varnish and the linkage to a dental home where a children would receive dental services will decrease expenditures for emergency department and operating rooms to treat advanced caries (cavities or tooth decay).

The Department states the maximum exposure of the proposed benefit is approximately $2,337,500 [(20,000 children X $38 per encounter X 2 annual applications = $1,520,000) + (15,000 children X $54.50 = $817,500)], of which 50% or $1,168,750 would be state general funds, assuming all eligible children participate. However, the Department anticipates a slow uptake of this service and thus the high-end cost may not be realized for 3 to 4 years. Thus initial costs of the program will be less and are dependent on the number of providers who avail themselves of the required training and the number of children seen by those providers. In addition, the Department states this maximum exposure estimate is not intended to represent cost avoidances by preventing or arresting dental caries in young children. The Department states in FY 2009 DHHS expended approximately $313,245 in emergency department and operating room (including hospitals and ambulatory surgical centers) for children aged 0-3, 97% of whom were treated due to caries. This figure does not include ancillary charges such as anesthesia, and professional services. For calendar years 2007 and 2008, DHHS expended $740,558 and $904,415 respectively on children aged 0-4, for operating room encounters to treat caries, these figures are inclusive of ancillary costs such as anesthesia, recovery room, pharmacy, and like costs. The Department is unable to determine when such cost avoidances will be realized or how substantial the savings might be. The Department states they would anticipate that application of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program which requires States, among other things, to ensure dental access to Medicaid enrolled children. In order for a dental encounter to count for EPSDT compliance, the encounter must be with a dentist. Accordingly, better linkage of young children with dentists will have an indeterminable benefit for DHHS in relation to its EPSDT mandates as well as potentially improving quality of life for Medicaid enrolled children.

The Office of Legislative Budget Assistant states this bill was a request of the Commission to Study Preventing Dental Disease among New Hampshire's Children which was established pursuant to Chapter 130:2. Laws of 2009. The final report of the Commission issued November 1, 2009 includes the following information –

- The Hawkins Consent Decree (a court-ordered settlement agreement approved in the US District Court in the case of Hawkins v. Commissioner of the Department of Health and Human Services) states that, "Prior to age three oral health screening shall occur in the context of a well-child visit." It further requires that the NH DHHS "shall use its best efforts to provide primary care providers with education and training they need-

and to encourage them to take the actions necessary-for the delivery of appropriate oral health screenings to Class Members under the age of three including but not limited to information about prevention of transmission of caries-causing bacteria from parent to child, prevention of early childhood caries, fluoride supplementation, oral hygiene practices tailored to young children, diet and nutrition and when and how to refer Class Members under age three for a dental screening."

- According to the Commission, at the time of the report Northeast Delta Dental had verbally agreed to reimburse trained primary care providers who treat children enrolled in NH Healthy Kids for providing oral risk assessments, anticipatory guidance to the caregiver, fluoride application followed by a referral to a dental home.

- Training programs are available both locally and nationally for primary-care medical providers interested in performing oral health screenings and preventive dental services on high to moderate risk young children. This includes a program by Southern New Hampshire Area Health Education Center and the American Academy of Pediatrics web-based training program.

The Office of Legislative Budget Assistant has prepared this fiscal note in accordance with RSA 14:46, V.

New Hampshire Medicaid and Healthy Kids-Gold Services

Recipient Information About:

Recipient Responsibilities

Transportation

Service Limits

Co-payments

Non-Covered Services

Prescription Drugs

Prior Approval

Department of Health and Human Services
Medicaid Benefits Administration
129 Pleasant Street
Concord, New Hampshire 03301
1-800-852-3345 ext.4344
TDD Access: Relay NH 1-800-735-2964

RECIPIENT RESPONSIBILITIES

The NH Medicaid and Healthy Kids-Gold programs pay for certain medical items, supplies, and services to improve and maintain your health. For the program to work for you, it is important that you:

- show your NH Medicaid or Healthy Kids-Gold identification card to each provider you see, at each visit, before you receive any service;
- ask the medical provider if she/he is enrolled with NH Medicaid or Healthy Kids-Gold;
- ask the medical provider if the service(s) you need will be covered by NH Medicaid or Healthy Kids-Gold;
- keep track of what services you receive;
- inform your Department of Health and Human Services' District Office (DO) immediately if your name, or address changes (addresses are listed on the back panel); and
- keep every appointment and follow the treatment plan recommended by the provider. Failure to keep appointments may jeopardize the outcome of your care and/or result in your dismissal from your provider's practice.

If you do not follow these procedures you may incur bills, which **you will be required to pay** and dismissal from the provider's practice could result.

You are responsible for payment of all bills for services not covered by NH Medicaid or Healthy Kids-Gold, for services received from providers not enrolled in NH Medicaid or Healthy Kids-Gold or not accepting new NH Medicaid or Healthy Kids-Gold patients, or for services which exceed any service limit.

If you have any questions about NH Medicaid or Healthy Kids-Gold services, please call Medicaid Client Services at 1-800-852-3345 ext. 4344 (in-state only) or (603) 271- 4344.

TRANSPORTATION

Ambulance Service - is covered to and from the nearest acute care hospital with appropriate treatment facilities when other methods of transportation are medically contraindicated and when it is certified as medically necessary by a physician or other qualified person. Ambulance service is **not** covered if used for the recipient's convenience or for transportation to and from a medical provider other than as above.

Wheelchair Van Service - is covered for up to 24 trips per year, whether one way or round trip. This service is covered only if **all** of the following conditions are met:

- the use of the wheelchair van is certified as medically necessary by the recipient's physician or other qualified person;
- the recipient is confined to a wheelchair for mobility; and
- the transportation is to and from a medical provider, returning directly to the recipient's home or nursing facility.

Private or Public Transportation to Medical or Dental Services may be reimbursed if arrangements are made in advance. If you need help finding a ride to a medical or dental appointment, need reimbursement for gasoline used when traveling to a medical or dental appointment, or if you would like to help transport others, please contact the Medicaid Transportation Coordinator, at: 1-800-852-3345 ext. 3770 (in-state only) or (603) 271-3770, for information about how to enroll as a recipient or volunteer driver. If bus transportation is submitted for reimbursement, a receipt for the bus fare is required.

SERVICE LIMITS

The services below are limited. Limits are per person, per fiscal year (July 1 - June 30). Keep track of the medical services you use because if you go over these limits, you may have to pay the bills.

If medically necessary services are required after you have reached the service limit, your medical provider should contact Medicaid Medical Services for a possible approval to go over limits **PRIOR** to providing additional services. Refer also to pamphlet 77h, "Healthy Kids and Healthy Teens", for information about services available to persons under age 21. It is important to let your Family Services Specialist know if you have other health insurance or if there are any changes in your insurance, because it may affect your limits.

Service limits do not apply to recipients residing in nursing facilities or recipients participating in the Home and Community Based Care (HCBC) Waiver Programs.

The limits for each service are:

Physician Services - 18 visits per year
(This limit does not apply to pregnant women or to persons under age 21.) Physician services include services provided by doctors, private psychiatrists, doctors of osteopathy, advanced practice registered nurses (APRN), ophthalmologists and physician assistants. A visit means all physician services (other than hospital inpatient) provided in one day by one physician, but it does not include laboratory tests or diagnostic x-rays.

X-Ray (Diagnostic) - 15 X-rays per year
Radiation therapy is not counted toward this limit.

Outpatient Hospital - 12 visits per year
Outpatient visits are those visits to the outpatient department of a hospital, **including emergency room services**.

Dental Services
For persons age 21 and over, coverage is limited to the treatment of acute pain or infection. For persons under age 21, most dental services are covered, such as regular check-ups every six (6) months, cleanings, fluoride treatment, x-rays, sealants, fillings, root canals, and extractions. Please refer to pamphlet 77o, "Dental Services for Children."

Physical Therapy, Occupational Therapy, Speech Therapy - 80 units per year
A unit is fifteen (15) minutes of therapy. Units may be used for one type of therapy or in any combination of therapies.

Podiatrist (Foot Doctor) - 12 visits per year
A visit means all podiatrist services provided on one day by one podiatrist.

Community Mental Health Services -
Your Community Mental Health Center can explain any limits on their services.

Psychotherapy - 12 visits per year if provided by an APRN or non-physician provider.

Vision Care Services

- One complete eye exam every 12 months to determine the need for glasses
- When certain prescription requirements are met, one pair of single vision or bifocal glasses or one pair each reading and distance glasses.
- Only approved frames and lenses are covered.
- Replacement glasses only when vision changes of 1/2 diopter or more occur in each eye
- One repair of glasses per year - replacement of broken parts only

Prescription Drugs
There is no yearly limit on prescribed drugs. Certain maintenance medications may have supply limits. Your pharmacist will be able to identify these for you.

CO-PAYMENTS

Prescription Drugs
In most cases, you must pay a co-payment. The pharmacy will collect this co-payment from you, and NH Medicaid or Healthy Kids-Gold will pay the rest of the bill.

There are two (2) amounts of co-payment depending on the type of prescription product dispensed:

- when a generic product is dispensed, the co-payment will be $1.00 for each prescription or refill
- when a brand name prescription, or a compound product prescription which the pharmacist mixes him/herself, is dispensed, the co-payment will be $2.00 for each prescription or refill

There is no co-payment required:

- of recipients under the age of 18
- of recipients residing in a nursing facility
- of recipients participating in the Home and Community Based Care (HCBC-ECI) waiver programs
- of recipients receiving services that relate to pregnancy or any other medical condition that might complicate the pregnancy
- for family planning products that require a prescription
- for Clozaril (Clozapine) prescriptions

SERVICES NOT COVERED BY NH MEDICAID OR HEALTHY KIDS-GOLD (PARTIAL LIST)

If you receive one of these services, you will have to pay for it. Ask the provider, before receiving a service, if the service will be covered by NH Medicaid or Healthy Kids-Gold.

The following services are **non-covered**:

- Acupuncture and Biofeedback
- Experimental or investigational procedures as determined by Medicare guidelines
- Experimental or investigational medication not approved by the FDA
- Reversal of voluntary sterilization
- Sex change operations
- Operations for impotency
- Operations, devices, medications, and procedures for the purpose of contributing to or enhancing fertility or procreation
- Cosmetic surgery or procedures
- Hypnosis - except when performed by a psychiatrist as part of an established treatment plan
- Services or items that are free to the public
- Physician care in a non-medical government or public institution
- Services for work related ailments or injuries
- Visual or auditory training (auditory trainer devices are covered)
- Dietary services including commercial weight loss and exercise programs
- Homemaker services, except for HCBC-ECI recipients
- Academic performance testing not related to a medical condition
- Detoxification services provided outside an acute care facility or a medical services clinic
- Halfway houses
- Hospital inpatient care which is not medically necessary
- Respite services and child care
- Services directly related to non-covered services, procedures, or items

SERVICES THAT NEED PRIOR APPROVAL

The services below need special approval **BEFORE** you receive the service. This approval is called **prior authorization.**

The provider must contact the Department of Health and Human Services, Medicaid Medical Services, 129 Pleasant Street, Concord, NH, and obtain prior authorization to provide the following services:

- **Out-of-State Inpatient Hospitalization** (except for emergencies)
- **Private Duty Nursing**
- **Durable Medical Equipment,** such as hospital beds, power wheelchairs, and CPAP machines.
- **Incontinence Supplies for Adults**
- **Organ Transplant Services**, except kidneys
- **Dental Services -** The provider must obtain prior authorization for comprehensive and interceptive orthodontic treatment, dental orthotic devices, surgical periodontal treatment, extractions of asymptomatic teeth, and certain orthodontic treatment for malocclusions.
- **Prescription drugs** - There are some circumstances under which the provider must obtain prior authorization for prescription drugs. Providers have been instructed on the prescription drug prior authorization process.
- **X-rays** - There are some circumstances under which the provider must obtain prior authorization for certain x-rays. Providers have been instructed on the x-ray prior authorization process.
- **Communication Devices** - The recipient or provider must contact the Augmentative Communication Equipment Services Consultant at 1-800-397-0191 for requirements regarding coverage and prior authorization.

The provider must contact the Department of Health and Human Services, Bureau of Elderly and Adult Services, 129 Pleasant St. Concord, NH, and obtain prior authorization to provide the following:

- Nursing Facility Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES DISTRICT OFFICES

BERLIN
650 Main St., 2nd floor
Berlin, NH 03570
603-752-7800 or
800-972-6111

CLAREMONT
17 Water St.
Suite 301
Claremont, NH 03743
603-542-9544 or
800-982-1001

CONCORD
40 Terrill Park Dr.
Concord, NH 03301
603-271-6200 or
800-322-9191

CONWAY
73 Hobbs St.
Conway, NH 03818
603-447-3841 or
800-552-4628

KEENE
809 Court St.
Keene, NH 03431
603-357-3510 or
800-624-9700

LACONIA
65 Beacon St. W.
Laconia, NH 03246
603-524-4485 or
800-322-2121

LITTLETON
80 N. Littleton Rd.
Littleton, NH 03561
603-444-6786 or
800-552-8959

MANCHESTER
195 McGregor St.
So. Tower, Suite 110
Manchester NH 03102
603-668-2330 or
800-852-7493

NASHUA
19 Chestnut St.
Nashua NH 03060
603-883-7726 or
800-852-0632

PORTSMOUTH
30 Maplewood Ave.
Suite 200
Portsmouth NH 03801
603-433-8300 or
800-821-0326

ROCHESTER
150 Wakefield St.
Suite 22
Rochester, NH 03867
603-332-9120 or
800-862-5300

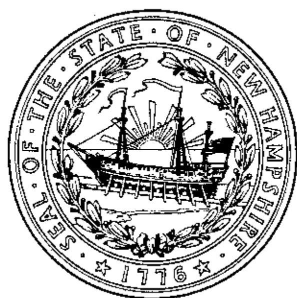
SALEM
154 Main St., Suite 1
Salem, NH 03079
603-893-9763 or
800-852-7492

TDD Access: Relay NH 1-800-735-2964

Form 77L
11/09
SR 09-xx

NEW HAMPSHIRE MEDICAID and HEALTHY KIDS-GOLD

DENTAL SERVICES FOR CHILDREN



Department of Health and Human Services
29 Hazen Drive
Concord, New Hampshire 03301-6504

1-800-852-3345

TDD Access: Relay NH 1-800-735-2964

Your Child Can Have A Perfect Smile!

How to help your child have healthy teeth and gums for a lifetime:

- Be sure all teeth are brushed and clean after meals and snacks, and before bedtime.
- Follow your doctor or dentist's directions for daily fluoride use to prevent cavities.
- Avoid sugary drinks, sticky snacks, and candy; germs that cause cavities feed on sugar.
- Do not share toothbrushes, cups, or food; germs that cause cavities are passed from one person to another.
- Do not put your child to bed with a bottle; germs that cause cavities are more active when you sleep.
- Take your child for regular dental check-ups every six months starting before age one (1). Regular dental check-ups allow dentists to find and treat tooth decay early.
- Take away sippy cups before your child is 15 months old.
- Set a good example by brushing and flossing your own teeth every day.

Most dental care is available at no cost for persons under 21 receiving NH Medicaid.

To have any dental care paid for by NH Medicaid, your child must be currently enrolled in NH Medicaid and the dentist must be an enrolled NH Medicaid provider.

Dental benefits that are covered under NH Medicaid include:

- Check-ups every six months
- Cleaning and fluoride
- Home fluoride rinses by prescription
- Fillings and Sealants
- Emergency care and anesthesia
- Most other routine and emergency care

Dental treatments that are not covered include:

- Bleaching and other cosmetic procedures
- Gold or porcelain crowns

Covered dental benefits for NH Medicaid recipients over age 21 are limited to:

- Treatment of acute pain and infection

For help finding a dentist, call Medicaid Client Services

- In NH, call 1-800-852-3345, ext. 4344
- Outside NH, call (603) 271-4344

For help with a ride or money for gas, call Medicaid Client Services

- In NH, call 1-800-852-3345, ext. 3770
- Outside NH, call (603) 271-3770

If you need to cancel your appointment, please call your dentist 24 hours in advance. It is easier to get future dental appointments if you go to your scheduled appointments or you cancel ahead of time!

DEPARTMENT OF HEALTH AND HUMAN SERVICES DISTRICT OFFICES

BERLIN
231 Main St.
Berlin, NH 03570
603-752-7800 or
800-972-6111

CLAREMONT
17 Water St.
Suite 301
Claremont, NH 03743
603-542-9544 or
800-982-1001

CONCORD
40 Terrill Park Dr.
Concord, NH 03301
603-271-6200 or
800-322-9191

CONWAY
73 Hobbs St.
Conway, NH 03818
603-447-3841 or
800-552-4628

KEENE
809 Court St.
Keene, NH 03431
603-357-3510 or
800-624-9700

LACONIA
65 Beacon St. W.
Laconia, NH 03247
603-524-4485 or
800-322-2121

LITTLETON
80 N. Littleton Rd.
Littleton, NH 03561
603-444-6786 or
800-552-8959

MANCHESTER
195 McGregor St.
So. Tower, Suite 110
Manchester NH 03102
603-668-2330 or
800-852-7493

NASHUA
19 Chestnut St.
Nashua NH 03060
603-883-7726 or
800-852-0632

PORTSMOUTH
30 Maplewood Ave.
Suite 200
Portsmouth NH 03801
603-433-8300 or
800-821-0326

ROCHESTER
150 Wakefield St.
Suite 22
Rochester, NH 03867
603-332-9120 or
800-862-5300

SALEM
154 Main St., Suite 1
Salem, NH 03079
603-893-9763 or
800-852-7492

TDD Access: Relay NH 1-800-735-2964

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11/06
SR 04-xx

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1537 Date 1/12/2010

Committee Health, Human Services & Elderly Affairs

**** Please Print All Information ****

Name	Address	Phone	Representing	Pro	Con
Sen. Peggy Gilmour			Dist. 12	✓	
Catrina Watson	7 N. State	224-1909	NHMS	✓	
Denise Brewitt	21 S Fruit St. Concord			✓	
Alida Millham			Belknap Dist 5	✓	
LESLIE MELBY	125 AIRPORT RD CONCORD		NHHA	✓	
Ellen Keith		271-2773	Gov. Comm on Disability	✓	
Kelley White		536-4000	Mid-State Health Center Plymouth Pediatrics	✓	

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1537

BILL TITLE: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

DATE: January 12, 2010

LOB ROOM: 205 **Time Public Hearing Called to Order:** 11:00 AM

Time Adjourned: 12:10 PM
Reconvened, recessed from 12:10 PM: 2:40 PM
Time Adjourned: 4:00PM

(please circle if present)

Committee Members: Reps. Rosenwald, Donovan, French, Schulze, Tilton, Butcher, Bridgham, E. Merrick, T. Russell, DiPentima, Miller, Batula, C. McMahon, Pilliod, Emerson, Case, Millham, Wells, Cebrowski and Kotowski.

Bill Sponsors: Reps. DiPentima, Rock 16; Pilliod, Belk 5; Millham, Belk 5

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Representative Rich DiPentima, prime sponsor – supports. He introduced the bill with a new amendment. The bill is a result of commission work. The bill requests primary care providers be allowed to provide preventive oral health services. Many children are sent to the operating room because of bad decay.

Dr. Susan Lynch, NH Pediatric Society – supports. Tooth decay is a most common childhood disease. Care in early childhood is critical. Obesity is another problem. Supports the state Medicaid program to cover these services for high risk children at least. It is part of a well child exam to look at the oral cavity. It is relatively new to say a child should be seen before age three years.

Representative DiPentima – there is no fiscal note hoping to get future dollars. Benefits of this program will be seen in six months to one year. The cost may be $40,000 a year for 5% of the population. Thirty six other states have a waiver to cover the cost. Training is the responsibility of the provider not the state.

Senator Peggy Gilmour – supports. She served on the Commission and supports the bill. It is well worth the state participation.

***Katie Dunn, State Medical Director, NH DHHS.** See written testimony. The oral health cleaning lasts about twelve hours. The parents must cooperate with the care of the children's oral health. General dentists will need to be approached to provide or augment the care being provided by pediatric dentists and general dentists who do see children. Oral care must be ongoing. Our culture doesn't have children being seen before age three years.

***Suzanne Boulter, M.D., NH Pediatric Society – supports.** See written testimony. There are only 24 Pediatric Dentists, 382 licensed pediatricians, and 636 licensed family physicians in NH. The opportunity for oral screening by physicians is a potential. The skills will have to be learned. Children with Medicaid have a problem getting dental care. A physician or dentist does not have to accept Medicaid. Need to get the Medicaid coverage for children to have oral screening by the physician. It would take 5-7 minutes for the doctor to do the oral screening including teaching and application of fluoride. Reimbursements vary from $15 - $70.

***Michael Matos, M.D., NH Pediatric Society – supports.** See written testimony. Forty percent of his practice receives Medicaid. Two dentists in his area accept Medicaid.

***Hope Saltmarsh, Bow, NH – supports.** See written testimony.

***Kathy Mandeveille, R.N., Bedford, NH – supports.** See written testimony.

***Angela Boyle, NH Oral Health Coalition – supports.** See written testimony. New Hampshire is the only New England state that does not cover this service. The cost is $641,000 for 436 children to receive this treatment of dental disease.

***Representative Alida Millham, co sponsor – supports.** See written testimony. She speaks for Dr. Kelly White and submitted pictures of bad mouths.

James Williamson, NH Dental Society – supports. He supports the concept of the bill. The Dental Society plan is to be presented next week. He's working with the Bi State Community Care to recruit pediatric dentists. We have an increase in dental clinics in our state. It takes 2 to 3 years extra training for a pediatric dentist. You should get a child to a dentist by age one. Twelve or thirteen health centers in New Hampshire accept Medicaid. Dental rates vary according to the procedure. A dental home for each child is a national effort. There is a gigantic no show rate with Medicaid patients.

***Malone Cloitre, Southern NH AHEC – supports.** See written testimony. Reimbursement varies from state to state. Community Health Centers most frequently request this education. It is recommended doing the program at family practice or pediatric offices.

***Gail Garceau, President, NH Healthy Kids – supports.** See written testimony. New Hampshire is the only state in New England not providing this service. Healthy Kids Silver is to be considered for this program. It would need a state plan amendment.

Lisa Brit Solsky – Silver benefit is delivered through Northeast Delta.

Representative Pilliod, co sponsor – supports. The pediatrician's is the perfect place to start dental exams and referrals. He encourages pediatricians and family doctors to get the education.

***Lindsay Josephs, Endowment for Health – supports.** See written testimony. This bill is doing the right thing at the right time in a child's life.

Ellen Legg, NH Dental Hygienist Association – supports. This is a fantastic bill and a very good way to get these kids seen.

***Marie Mulroy, Breath NH – supports.** See written testimony.

Representative DiPentima – The costs are not known at this time.

Respectfully submitted,

Rep. Joan Schulze

Representative Joan Schulze, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 1537

BILL TITLE: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

DATE: 1/12/2010

LOB ROOM: 205 **Time Public Hearing Called to Order:** 11:00 AM 2:40

Time Adjourned: 12:10 AM 4:00

recessed to 2:40

(please circle if present)

Committee Members: Reps. Rosenwald, Donovan, French, Schulze, Tilton, Butcher, Bridgham, E. Merrick, T. Russell, DiPentima, Miller, Batula, C. McMahon, Pilliod, Emerson, Case, Millham, Wells, Cebrowski and Kotowski.

Sub cmte: Miller, Bridgham, Cebrowski

Bill Sponsors: Reps. DiPentima, Rock 16; Pilliod, Belk 5; Millham, Belk 5

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. DePentima prime sponsor introduced the bill with a new amendment. The bill is a result of Commission Work. The bill requests primary care providers be allowed to provide preventive oral health services. Many children are sent to the operating room be of bad decay.

Dr. Susan Lynch Tooth decay is most common childhood disease. Care in early childhood is critical. Obesity is another problem. Support the state Medicaid program cover these services for high risk children at least. It is part of a well child exam to look at the oral cavity. It is relatively new to say a child should be seen before age 3 years.

Rep. DePentima - No fiscal note hoping to get future dollars. Benefits of this program will be seen in 6 mos - 1 year. $40,000 a year may be the cost for 5% of population. 36 other states have a Waiver to cover the cost.

Training is the responsibility of the provider not the state.

Senator Peggy Gilmour - served on the Commission and supports the bill. It is well worth the state participation.

* Katie Dunn - State Medicaid Director

The oral health cleaning lasts about 12 hours. The

parents must cooperate with the care of the children's oral health
General dentists will need to be approached to provide or augment the care being provided by pediatric dentists & general dentists who do see children. Oral care must be ongoing. Culture to have children being seen before age 3 years

*Dr. Suzanne Boulter supports the bill
(5) 24 pediatric 382 licensed pediatricians
636 lic. family physicians
opportunity for oral screening by physicians is a potential
The skills will have to be learned.
Children with Medicaid have a problem getting dental care.
A physician or dentist does not have to accept Medicaid. Need to get the Medicaid coverage for children to have oral screening by the physician.
5-7 minutes for M.D. to do the oral screening including teaching, application of fluoride
Reimbursements varys $15-$70

*Dr Michael Matos - supports the bill 40% of his practice receive Medicaid
(6) 2 dentists in his area accept Medicaid

*(7) Hope Saltmarsh Supports

*(8) Kathy Mandeville RN Supports The bill
Public Health Background

(9)* Angela Boyle oral health coalition strongly supports
N.H. is the only N.E. State that doesn't cover this service
cost $641,000 for 436 children to receive treatment of dental disease

Rep. Millham - supports the bill speaking for Dr. Kelly White
*(10) Submitted pictures of bad mouths

(11) James Williamson N.H. Dental Society
Supports concept of bill. Dental Society plan is to be presented next week.
Working with Bi State Community Care to recruit pediatric dentists. Have an increase in dental clinics in our state. 2 to 3 years extra training for a pediatric dentist.

HB 1537 continued (3)

Get child into a dentist by age one.
12 13 health centers which accept Medicaid in N.H.
Dental rates vary according to the procedure
A dental home for each child is a national effort
There is a gigantic no show rate with Medicaid patients

(15) Malone Claitre Southern N.H. AHEC
Paula Smith not present in afternoon
Reimbursement vary from state to state
Community Health Centers mostly frequently request
this education
Recommend doing program at family practice
or pediatric offices

Gail Garceau President N.H. Healthy Kids
(13) Supports HB1137
only state in N.N. not providing this service
Healthy Kids Silver to be considered for this program
(Title 21)
would need a state plan amendment.

Lisa Brit Dolsky - Silver benefit delivered through
No East Delta

(14) Rep. Pilliod Supports the bill
Pediatrician is the perfect place to
start dental exams and referrals
Encourage pediatricians & family Docs to get
the education

(ENDOWMENT)

Lindsay Joseph   Endowment for Health   (4)

(15) Supports this bill: it is doing the right
☆ thing at the right time in a child's life

(16) Ellen Legg represents NH Dental Hygienist.
Supports this bill it is fantastic
It is a great way to get these kids seen.

Rep. DePentima. Costs are not known at this time

Sub-Committee Actions

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 1537

BILL TITLE: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

DATE: January 26, 2010

Subcommittee Members: Reps K. Miller, R. Bridgham, J. Cebrowski

Comments and Recommendations: "Sufficient". FN delivered to the LBA.

Amendments:

Sponsor: Rep. K. Miller OLS Document #: 2010 0232h

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. R. Bridgham

Seconded by Rep. K. Miller

Vote: 3-0

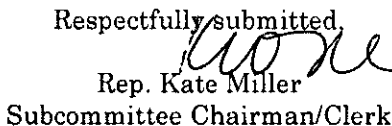
Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,



Rep. Kate Miller
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 1537

BILL TITLE: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

DATE: January 26, 2010

Subcommittee Members: Reps. K. Miller, R. Bridgham, J. Cebrowski

Comments and Recommendations: "Sufficient"
FN delivered to LBA

Amendments:

Sponsor: Rep. Miller OLS Document #: 2010-0232h

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. Bridgham

Seconded by Rep. Miller

Vote: 3-0

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Kate Miller
Subcommittee Chairman/Clerk

Rep. Miller, Belk. 3
January 21, 2010
2010-0232h
05/03

Amendment to HB 1537

1 Amend the title of the bill by replacing it with the following:
2
3 AN ACT allowing primary care providers to provide preventive oral health services to
4 children between 0 and 3 years of age under the state Medicaid program.
5
6 Amend RSA 126-A:4-g as inserted by section 1 of the bill by replacing it with the following:
7
8 126-A:4-g Children's Oral Health Initiative.
9 I. The department shall seek funding for a Medicaid children's oral health initiative
10 program as part of the department's budget for the biennium ending June 30, 2013, and each
11 biennium thereafter. The program shall provide reimbursement to primary care providers who
12 deliver preventative oral health services, such as dental screenings and fluoride varnish treatments,
13 to children between 0 and 3 years of age enrolled in the state Medicaid program. Primary care
14 providers who choose to participate in the program shall complete training approved by the
15 department and submit evidence of program completion to the department, which shall maintain a
16 list of trained providers. Program implementation, including adoption of rules required by
17 paragraph II, and submission of a Medicaid state plan amendment as required by paragraph III,
18 shall be contingent upon sufficient funding.
19 II. The commissioner shall adopt rules under RSA 541-A relative to administration of the
20 children's oral health initiative, including eligibility criteria, the type and frequency of services
21 covered, reimbursement rates, and provider training requirements. The department also shall
22 develop a list of approved training programs, which shall include, but may not be limited to, those
23 offered by the American Academy of Pediatrics and the Southern New Hampshire Area Health
24 Education Center. Upon implementation of the program, the department shall provide, upon
25 request, a list of dentists participating in the state Medicaid program to primary care providers in
26 the oral health initiative.
27 III. The department shall submit a Title XIX Medicaid state plan amendment to the Centers
28 for Medicare and Medicaid Services for the purpose of establishing the children's oral health
29 initiative.

2010-0232h

AMENDED ANALYSIS

This bill directs the department of health and human services to seek funding for a children's oral health initiative that would enable primary care providers to deliver preventive oral health services to children between 0 and 3 years of age under Medicaid. The program is contingent upon future funding and approval of a state Medicaid plan amendment.

Sub-Committee Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 1537

BILL TITLE: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

DATE: January 19, 2010

Subcommittee Members: Reps. K. Miller, R. Bridgham, J. Cebrowski

Comments and Recommendations: Lisabritt: Difficult to quantify savings,; Rep. Batula will offer an FN amendment; Rep. Pilliod statement of long term savings; Rep. DiPentima: 36 other states love the program. Lisabritt: reorder paragraphs.

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep. R. Bridgham

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Kate Miller
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION ON HB 1537

BILL TITLE: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

DATE: January 19, 2010

Subcommittee Members: Reps. K. Miller, R. Bridgham, J. Cebrowski

Pilliod, DiPentima

Comments and Recommendations: Lisa Britt: difficult to quantify savings; Rep Batula will offer FN amendment; Rep Pilliod statement of longterm savings; DiPentima: 36 other states have program - Lisa Britt - reorder paragraphs -

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.) [OTP/A circled]

Moved by Rep. Bridgham

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Retained (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Kate Miller
Subcommittee Chairman/Clerk

Lisa Britt how long to track
What cohort included
Prevention prediction
redeploy savings into oral health -

1/0-12 Pilot - $200K
Study component
PCP follow up w/ dental home; reimb
contingent
savings longer than biennium

stmt of longterm savings

Hawkins litigation

Rep Skinder - ER nurse

Medicaid

Rich DiP - VT $20,000 GF/yr
17,000 0-3 yr olds Medicaids
850 saw dentists
52% of dentists take Medicaid

Brigham -

Testimony

File
NB1537
K. Dunn

HB 1537
January 11, 2009 Talking Points
House Health, Human Services and Elderly Affairs Committee
Kathleen A. Dunn, RN, MPH
Medicaid Director
DHHS

- We understand the Department's responsibilities under this bill to be threefold: to create a primary care oral health project to be funded by the legislature in the Department's 2012-2013 biennial budget, to adopt administrative rules detailing the implementation of such a program and to submit a Medicaid State Plan Amendment to that effect in order to receive federal approval for matching funds.

- The Department can fulfill these responsibilities. In fact, the Office of Medicaid Business and Policy included a similar proposal in the 2010-2011 agency phase of the budget. Due to the many difficult choices that were before the policy makers in creating the current budget, this project did not receive the necessary funding to launch.

- The Department must request a technical amendment to the bill to reorder the schedule of deliverables for the funding request to come first and State Plan Amendment to come second. This is consistent with existing Medicaid business practice with CMS where program development, funding, rules, and policy, all come before a State Plan Amendment. Moreover, the State Plan Amendment signals to CMS the availabilty of state match for the services, which in the present case could not be guaranteed until or unless the proposal is funded in the final 2012-2013 budget.

- This will likely not be the sole Medicaid dental initiative proposed in our agency budget for 2012-2013.

- As a matter of policy, the Department sees the value in utilizing primary care physicians as one tool in our efforts to unite all children enrolled in Medicaid with a Dental Home where s/he receives all necessary preventative and restorative oral health care. As such, if carried out properly, this program could assist the Department in fulfilling its oral health requirements under Early and Periodic Screening Diagnostic and Treatment regulations.

HB 1537
Dr Suzanne Boulter

Representative Rosenwald
Chair, House Health, Human Services and Elderly Affairs Committee
Testimony on HB 1537
January 12, 2010

The National Academy for State Health Policy has published briefs in 2008 and 2009 documenting that using primary care providers to promote **preventive** oral hygiene and good nutritional habits, refer patients to a dental home by age 1 and to apply fluoride varnish as a proven caries reducing strategy has allowed states to have an opportunity to better serve young children and work toward a goal of reducing state expenditures on costly restorative care.

Oral health should no longer be separated from general health – as stated clearly by Dr David Satcher in the ***Surgeon General's Report on the Status of Oral Health in America.***

Primary care providers see children for well-child visits at least 12 times in the first three years of life as recommended by ***Bright Futures, 3rd Edition.***

This early and frequent access to infants and toddlers during well child visits presents a valuable opportunity for PCPs to assess a child's oral health, provide preventive oral health services, educate care givers on oral health practices, and refer for a dental visit *without the need for additional work force.*

In NH a recent Head Start survey of children showed that 31% had active dental caries and 40% had a history of caries. Nationally the incidence of early childhood caries has increased from 24% to 28% while the incidence of caries in all other age groups has decreased.

NH should follow the lead of 36 other states – including every other state in New England - who have engaged the medical community in sharing the responsibility for maintaining children's oral health.

The NH Board of Dental Examiners reports that there are approximately 757 practicing dentists but only 24 Pediatric Dentists, none of whom practice in the northern half of the state (Dental Services and workforce in NH 2010, NH Center for Public Policy).
There are about 382 licensed pediatricians and 636 licensed family physicians (not all of whom see infants and toddlers) in NH who can be trained to deliver the preventive screening oral health services.

I am submitting for your review written testimony from the president of the American Academy of Pediatrics, the president of the NH Pediatric Society and also from 15 pediatricians and pediatric nurse practitioners in the Seacoast area in support of this legislation.

Both the American Academies of Pediatrics and the American Academy of Pediatric Dentistry recommend that every child have an established dental home by age one. Unfortunately, there are not enough pediatric or general dentists in NH who will see infants and toddlers to establish a dental home making the role of the PCP crucial.

Although children on Medicaid or children lacking in dental insurance are most at risk for childhood caries, they are least able to access dental services in the first three years of life when the caries process can be prevented.

Virtually all these low income children have a medical home and most are covered by Medicaid. That is why most states (36) have followed the successful strategy of reimbursing PCPs to deliver oral health preventive services as an addition to their well child visits. Data from North Carolina, the state that has provided training and reimbursement the longest, shows that there has been a 38% **decrease** in the need for restorative dental care at age 3 in children on Medicaid and also a significant **increase** in dental visits – a win/win situation!

Primary Care Providers in New Hampshire have willingly welcomed Medicaid children into their practices in spite of significantly reduced reimbursement compared to commercially insured patients *because it's the right thing to do.*

However, asking PCPs to develop new skills, learn additional background information about oral health via computer or hands on training, increase the time for each office visit (resulting in fewer office visits per day) and pay for staff training, screening tools and fluoride varnish supplies without providing additional reimbursement will not be an effective strategy to bring screening to those who are most in need.

HB1537 is a smart approach to establishing the necessary building blocks to improve oral health in very young children in NH. It is time for us to join the 36 other states who have found that engaging the medical community in prevention of early childhood caries makes perfect sense to reduce the burden of pain in children while saving significant costs of restorative treatment in the operating room later on.

Suzanne Boulter, MD
Adjunct Professor of Pediatrics
Dartmouth Medical School

Faculty Pediatrician
NH Dartmouth Family Medicine Residency

Wolfeboro Pediatrics
A Department of Huggins Hospital

Medical Arts Center, Suite C, 240 South Main Street
PO Box 599, Wolfeboro, NH 03894-0599
603.569.7620 fax 603.569.7619
www.hugginshospital.org

Harley W. Heath, MD
Michael E. Matos, MD
Deborah A. Stone, PNP

File

HB1537

Pediatric Oral Health Initiative in NH

Michael Matos, MD/FAAP

- Compared to more affluent peers, preschoolers in poverty....
  - have twice the incidence of tooth decay
  - experience dental pain twice as often
- Poor dental health persists - in the Gov. Wentworth Regional School District, dental disease is the 2nd most common cause of school absenteeism

- Pediatricians do not want to be dentists, but dental health is part of overall health

- The Amer. Dental Assoc. & Amer. Acad. of Pediatric Dentistry recommend a first dental visit at *no later than 1 yo*
  - Of the ~7 dentists in the Wolfeboro area, only 2 see children under 2 yo
  - Closest pediatric dentist offices to southern Carroll County are in
    - Rochester (practice closed to new Medicaid patients) &
    - Concord (primarily used as referral center by local families)

  - Pediatricians see children at 0, 1, 2, 4, 6, & 9 months for well care
  - The pediatrician / parent / patient relationship is well established by 1 yo

- THE BOTTOM LINE - how are dollars for dental care best spent?
- Prevention is the key - the story of Patient DC

  - Followed from birth at Wolfeboro Pediatrics
  - Guardians reported inability to find a dentist willing to see DC
  - At age 5, DC developed severe dental caries, abscess, and pain
  - Dental pain affected speech, sleep, & behavior
  - Hospitalization alone (i.e., not including provider charges) cost $17,000
  - If pediatricians could be reimbursed $50 per treatment, then *340* dental assessments & treatments could have been done for that cost

Huggins Hospital

mmatos.wp@hugginshospital.org

File
HB1537

Testimony in Support of House Bill 1537
January 12, 2010

To: Representative Cindy Rosenwald, Chair
NH House Health, Human Services & Elderly Affairs Committee

Good morning Madam Chair and committee members,

My name is Hope Saltmarsh. I have been a NH dental hygienist for almost 30 years and I have a Masters Degree in Adult Education. For 4 years, starting in 2002, I was a consultant for an Endowment for Health grant educating physicians and staff about early childhood caries. I helped develop a pilot program for early childhood caries (ECC) screenings, anticipatory guidance, and referrals to area dentists. Since that program ended in 2006, I have been a faulty member for Southern NH Area Health Education Center. I assisted in the current ECC curriculum development and have delivered presentations to many NH primary care physicians and their staff, as well as Maternal and Child Health, Head Start, WIC, and childcare center staff.

It has been my consistent experience that primary care providers are very interested in the training and recognize the value of oral health interventions they could provide. But, they are frustrated by the lack of a system that can provide adequate dental services to the children they identify as needing services. Without reimbursement, medical providers are unable to institute effective oral health preventive services in their own offices. The costs associated with staff training, increased time with patients, and supplies must be offset by adequate reimbursement.

The National Oral Health Policy Center at Children's Dental Health Project is a non-profit organization in Washington D.C. that is funded by the Maternal and Child Health Bureau of the Department of Health and Human Services and by Health Resources and Services Administration. I have submitted a copy of their October 2009 publication: *Better Health at Lower Costs: Policy Options for Managing Childhood Tooth Decay.* Please refer to *Trendnotes* for the following:

- They recommend targeting "intensive intervention to those children at highest risk for the disease". (p. 1) Those at highest risk are low-income and minority children.
- "Dental costs for children enrolled in Medicaid for 5 continuous years who have their first preventive visit by age one are nearly 40% less ($263 compared to $447) than for children who receive their first dental visit after age one." (p.2, column 2)
- "Advanced restorative dental care needed by roughly 15% of children and "catastrophic" care needed for 5% of children are estimated to consume 75% of all pediatric dental expenditures among low-income children." (p.4, column 1)
- Policy recommendations (p.6, column 1) include:
  - "Encourage integration of oral health in primary care including prenatal visits."
  - "Strengthen public (e.g.Medicaid, CHIP)...financing systems to reimburse dental and primary care providers for fluoride varnish application, dental caries management activities, and patient referrals to appropriate care."

I support HB 1537 as cost-effective policy to maintain the oral health of NH's high risk children.

File
HB1537
K. Mandeville RN

Testimony – HB 1537
Preventive Oral Health Services for Children

Chairman Rosenwald and Members of the House Health, Human Services and Elderly Affairs Committee, my name is Kathy Mandeville. I am a public health nurse, I live in Bedford, and I come before you today **in support of House Bill 1537**.

It is my understanding that this bill would enable an amendment to NH's Title XIX Medicaid state plan which would authorize and reimburse NH primary care providers for providing NH's youngest children with preventive oral health care.

This recommendation is consistent is with the American Academy of Pediatrics' *2008 Policy Statement - Preventive Oral Health Intervention for Pediatricians*[1].
It is the Academy's recommendation, shared by the American Dental Association and the American Academy of Pediatric Dentistry that children should have an oral health examination, education and counseling, and establish a "dental home" with a dentist by one year of age.

This recommendation makes a great deal of sense. Children who have healthy teeth and gums are likely to enjoy the same as adults, and it is now common knowledge that oral health impacts our overall health. But the reality is that many children – especially those whose families are low income – are not seen by dentists until they are pre-schoolers or later. "Tooth decay affects more than one-fourth of U.S.• children aged 2–5. About half of all children and two-thirds of children aged 12–19 from low income families have had decay"[2].

Fortunately, most parents – including low income parents - do bring their infants and young children for regular pediatric care during these early months and years. These visits are almost exclusively preventive care – assessing health, immunizations to prevent serious disease, and guidance to promote healthy growth and development. There may be as many as six (6) well-child visits in the first year alone. Primary health pediatric providers have ample opportunity establish a relationship with parents, and with regular assessments – recognize potential health risks.

The American Academy of Pediatrics recommends that primary care pediatric providers should periodically conduct oral health risk assessments, with the goal to "anticipate and prevent caries initiation BEFORE the first signs of disease"[3]. The assessment considers not only dental health, but the child's diet, and the parents' educational and socio-economic capacity.

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[1] American Academy of Pediatrics. Policy Statement. Preventive Oral Health Intervention for Pediatricians. Pediatrics. vol. 122 number 6, December 2008. pp. 1387-94.
[2] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Oral Health – Preventing Cavities, Gum Disease and Tooth Loss 2009. Accessed January 8, 2010 at: [illegible]
[3] Ibid. p. 1388.

Testimony – HB 1537
Preventive Oral Health Services for Children

For those children found to be at moderate to high risk of oral disease and without access to a dental home, pediatric primary care providers should provide additional dietary and oral hygiene counseling. Additionally, they may consider a preventive intervention – the application of a professionally applied topical fluoride. One of these topical fluoride preparations - fluoride varnish – has been found to very effective in reducing dental decay. Fluoride varnish is inexpensive, and the application can be done in minutes by a trained practitioner, during a pediatric visit.

In New Hampshire, Medicaid funds primary pediatric health care, and it funds dentists for diagnostic, preventive and restorative care. However, it is my understanding that Medicaid does not reimburse primary pediatric care providers for conducting oral health assessments, nor are they reimbursed for applying topical fluoride for young children with moderate to high risk of dental decay who are unable to establish a dental home. This does not make sense to me.

This bill stipulates that primary care pediatric providers must have training in order to participate in these activities. The training is currently available through the Southern NH Area Health Education Center, as well as on line through the American Academy of Pediatrics[4].

Our state is in a fiscal crisis. Commissioner Toumpas has the task of assuring that every health dollar is spent wisely. Preventing dental decay is far less costly than treating dental decay. As you are offered testimony on this bill, please inquire as to how many 3rd grade NH children are found to have untreated decay. How many NH children are seen in emergency departments each year for dental pain and infection and the cost of that care. Ask what percentage of NH children on Medicaid have visited a dentist and at what ages, and what was the Medicaid cost for treating dental decay.

If we are truly interested in reducing dental decay in NH's children, we need to focus on preventing decay in infants and very young children. If the children MOST likely to have dental decay, and LEAST likely to visit a dentist are children from low income families – most of whom are Medicaid-eligible – then we need to promote interventions that are timely, evidence-based and accessible.

Thank you for supporting this bill.

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[4] http://www.aap.org/commpeds/dochs/oralhealth/cme/index.htm

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

POLICY STATEMENT

Preventive Oral Health Intervention for Pediatricians

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Section on Pediatric Dentistry and Oral Health

ABSTRACT

This policy is a compilation of current concepts and scientific evidence required to understand and implement practice-based preventive oral health programs designed to improve oral health outcomes for all children and especially children at significant risk of dental decay. In addition, it reviews cariology and caries risk assessment and defines, through available evidence, appropriate recommendations for preventive oral health intervention by primary care pediatric practitioners. *Pediatrics* 2008;122:1387–1394

PURPOSE/INTRODUCTION

Review of Circumstances Leading to Development of This Policy

Oral health is an integral part of the overall health of children.[1] Dental caries is a common and chronic disease process with significant consequences. As health care professionals responsible for the overall health of children, pediatricians frequently confront morbidity associated with dental caries. Because caries is a nonclassic infectious process (arising from shifts in subpopulation ratios of established normal flora), pediatricians have an opportunity to prevent, intervene, and, in collaboration with dental colleagues, manage this disease.

Justification of Policy

The prevalence of dental caries for the youngest of children has not decreased over the past decade, despite improvements for older children.[2] Data from the Medical Expenditure Panel Survey revealed that 89% of infants and 1-year-olds had office-based physician visits annually, compared with only 1.5% who had dental visits. Consequently, visits to physicians outnumbered visits to dentists at 250 to 1 for this age group.[3] Because the youngest of the pediatric patient population visit the pediatrician more than the dentist, it is critical that pediatricians be knowledgeable about dental caries, prevention of the disease, and interventions available to the pediatrician and the family.

Rationale for Format

This policy statement is an effort to assist the primary care pediatric practitioner in addressing issues of dental caries and general oral health. The statement begins by building a knowledge base regarding the caries process that can serve as a foundation for understanding prevention and intervention strategies. After explaining the science of cariology, assessment of caries risk is described to assist the pediatrician in deciding which preventive and interventional strategies need to be used. Specific prevention and intervention strategies are then described and explained.

In addition, the concept and importance of the dental home as well as strategies for improving the connection of the medical and dental homes are presented. Last, recommendations are provided to assist the pediatrician with implementation of the provided information.

BACKGROUND CONCEPTS

Cariology

The most common oral disease encountered by children is dental caries. Dental caries is a nonclassic infectious disease[4] that results from an interaction between oral flora and dietary carbohydrates on the tooth surface. To adhere to tooth structure, oral flora utilize dietary sugars to create a sticky biofilm that is referred to as dental plaque. Dietary sugar can change the biochemical and microbiologic composition of dental plaque. In the presence of a high-carbohydrate diet, cariogenic organisms constitute a greater portion of the total bacterial population.[5,6] Acids

produced by bacterial fermentation of carbohydrates reduce the pH of dental plaque to the point at which demineralization of the enamel occurs. The initial carious lesion appears as an opaque white spot on the enamel, and progressive demineralization results in cavitations of the teeth. Dental caries is a process, and loss of tooth structure (a dental cavity) is an end stage in the process.[7]

Human dental flora, generally regarded as qualitatively stable once established and site specific to human dentition, is believed to consist of more than 1000 different organisms, of which only a limited number are associated with dental caries.[8] *Streptococcus mutans* is most strongly associated with dental caries and is considered to be an indicator organism of a subpopulation of cariogenic organisms. *S mutans*, like its related cariogenic cohorts, has the ability to adhere to enamel and is uniquely equipped to produce significant amounts of acid (acidogenic) and endure within that acidic environment (aciduric).

Dental flora adheres to the teeth by creating a tenacious and highly complex biofilm referred to as dental plaque. Dental plaque is capable of concentrating dietary sugars; therefore, the chronic consumption of sugary foods and liquids will continually recharge the plaque matrix, resulting in copious supplies of sugars within the plaque matrix. *S mutans* and other cariogenic flora will then ferment available sugars, resulting in high levels of lactic acid, a decreased local pH (~5.0), and demineralization of dental enamel (at an approximate pH of ≤5.5). Because *S mutans* and its aciduric cohorts continue to thrive at low pH, the resulting environment selects against nonaciduric flora, creating a shift in the subpopulation ratio of benign to aciduric flora. As this process continues over multiple generations, aciduric organisms incur an upregulation of virulence genes that allow them to thrive at even lower pH (4.0). Diet-mediated shifts in subpopulation ratios of dental flora are instigated by significant sugar intake (environmentally selecting for carious organisms). Therefore, significant sugar intake is a driving cause of the caries process.

Preventive Strategies

An understanding of normal dental flora serves as a foundation for the development of preventive strategies, with 2 important considerations. First, dental flora exists in a symbiosis with the human species. Second, only a small number of the organisms within dental flora cause caries. Therefore, our objective is not to eliminate all dental flora but to suppress the cariogenic bacteria within the flora.

Preventive strategies can be differentiated into 2 distinct categories. Primary prevention involves optimization of maternal dental flora before and during colonization of the oral flora of the infant (during eruption of the primary dentition). This invaluable mode of prevention provides an opportunity for a reduction in the mother's constitutionally virulent, aciduric flora and downregulation of virulence genes within the aciduric flora, decreasing the child's risk of dental decay, and is the basis for first dental visit recommendations at 1 year or earlier made by various medical and dental organizations. This mode of prevention and its adjuncts are reviewed in detail in a policy statement from the American Academy of Pediatrics, "Oral Health Risk Assessment Timing and Establishment of the Dental Home."[9]

Secondary prevention is the continual and ongoing management of subpopulation ratios of benign and aciduric flora within dental plaque. This mode of prevention consists of managing the balance between causative factors and protective factors and is critical for preventing and reversing the caries process. Secondary preventive strategies are hierarchical and currently consist of dietary counseling, oral hygiene instruction, and judicious administration of fluoride modalities. Therefore, although all preventive modalities are important, modification of diet is most important, followed by oral hygiene compliance and then administration of fluorides.

By controlling risk factors before disease occurs, the probability of preventing disease, both in the immediate future and the long-term, is improved. Preventive strategies for this complex, chronic disease require a comprehensive and multifocal approach that begins with caries risk assessment.

Caries Risk Assessment

Caries risk assessment, based on developmental, biological, behavioral, and environmental factors, evaluates the probability of enamel demineralization exceeding enamel remineralization over time. The goal of risk assessment is to anticipate and prevent caries initiation before the first sign of disease. During the period of 1999–2002, 41% of US children 2 to 11 years of age had caries in primary teeth.[2] An earlier study noted that 25% of children 5 to 17 years of age had 80% of carious permanent teeth.[10] Assessing each child's risk of caries and tailoring preventive strategies to specific risk factors are necessary for improving oral health in a cost-effective manner.

Caries risk assessment is very much a work in progress. In a systematic review of literature regarding risk factors in primary teeth of children aged 6 years and younger, a paucity of studies of optimal (ie, longitudinal) design was noted.[11] A study that evaluated the reliability of multiple risk indicators determined that there is no consistent combination of risk variables that provide a good predictor of caries risk when applied to different populations across different age groups.[12] The authors concluded that the best predictor of caries in primary teeth was previous caries experience, followed by parents' education and socioeconomic status.[12] Although previous caries experience cannot be used as a risk indicator for the predentate or very young child, white-spot lesions, as precursors to cavities, can be considered analogous to previous caries experience when assessing the risk of a very young patient. An analysis of National Health and Nutrition Examination Survey (NHANES) III data revealed that children from households with low income levels are more likely to experience caries and have higher levels of untreated caries than their counterparts from higher-income households.[13] Collectively, children enrolled in Special Supplemental Nutrition Pro-

gram for Women, Infants, and Children (WIC) programs, Head Start, or Medicaid are at higher risk than are children in the general population.

Caries risk factors unique to infants and young children include perinatal considerations, establishment of oral flora and host-defense systems, susceptibility of newly erupted teeth, dietary transitioning from breast and bottle feedings to cups and solid foods, and establishment of childhood food preferences. Although preterm birth per se is not a risk factor, a child with low birth weight may require a special diet or have developmental enamel defects or disabilities that increase caries risk. Early acquisition of *S mutans* is a major risk factor for early childhood caries and future caries experience.[14] A reduction of the salivary level of *S mutans* in highly infected mothers can inhibit or delay colonization of their infants.[15] Although evidence suggests that children are most likely to develop caries if *S mutans* is acquired at an early age, this may be compensated in part by other factors such as good oral hygiene and a noncariogenic diet.[11] High-risk dietary practices seem to be established early, probably by 12 months of age, and are maintained throughout early childhood.[16] In addition to the amount of sugar consumed, frequency of intake is important.[17] Sugar consumption likely is a more significant factor for those without regular exposure to fluorides.[18] Children experiencing caries as infants and toddlers have a much greater probability of subsequent caries in both the primary and permanent dentitions.[19]

Early risk assessment targets infants and young children who traditionally have yet to establish a dental home. Unrecognized disease and delayed care can result in exacerbated problems, leading to more extensive, costly, and time-consuming care.

Risk-assessment strategies most applicable for screening purposes include those that are acceptable to patients, reliable, inexpensive, and performed easily and efficiently and require limited equipment/supplies. The American Academy of Pediatric Dentistry (AAPD) has developed a caries risk-assessment tool for use by dentists and primary care practitioners familiar with the clinical presentation of caries and factors related to caries initiation and progression (see www.aapd.org/media/Policies_Guidelines/P_CariesRiskAssess.pdf).[20] Radiographic assessment and microbiologic testing have been included in the caries risk-assessment tool but are not required. In addition, the American Academy of Pediatrics has created *Oral Health Risk Assessment Training for Pediatricians and Other Child Health Professionals*, which provides a concise overview of the elements of risk assessment and triage for infants and young children (see www.aap.org/commpeds/dochs/oralhealth/screening.cfm).[21]

The chronic, complex nature of caries requires that risk be reassessed periodically to detect changes in the child's behavioral, environmental, and general health conditions. All available data must be analyzed to determine the patient's caries risk profile. Periodic reassessment allows the practitioner to individualize preventive programs and optimize the frequency of recall and dental radiographic examinations.

SPECIFIC PREVENTIVE STRATEGIES

Dietary Counseling

Dietary counseling for optimal oral health in children should be an essential part of general health counseling. The recent policy statement from the American Academy of Pediatrics on prevention of pediatric overweight and obesity highlighted concerns about health problems in overweight children, including cardiovascular, endocrine, and mental health problems, and the importance of promoting healthy eating behaviors. Consumption of juice and sugar-sweetened beverages has been linked to childhood obesity and caries development.[22-25]

Sugars are a critical factor in caries development. Caries risk is greatest if sugars are consumed at high frequency and are in a form that remains in the mouth for longer periods.[26] Sucrose is the most cariogenic sugar, because it can form glucan, which enables bacterial adhesion to teeth and limits diffusion and buffering of acids. Although starch-rich foods pose a low caries risk, mixtures of finely ground, heat-treated starch and sucrose (eg, cereals, potato or corn chips) are also cariogenic.[27]

Human milk by itself does not promote tooth decay.[28] However, breastfed infants are at risk of caries when they receive sugary liquids or eat foods with sugars and fermentable carbohydrates.[26]

Parents and caregivers should be counseled on the importance of reducing exposure to sugars in foods and drinks. To decrease the risk of dental caries and ensure the best possible health and developmental outcomes, it is recommended that parents do the following:

- Breastfeed infants during the first year of life and beyond as is mutually desired.[29]
- After nursing, remove the breast from a sleeping infant's mouth and cleanse the gums and teeth after feedings and before bedtime.
- Discourage a child's sleeping with a bottle; any bottle taken to bed should contain only water.
- Limit sugary foods and drinks to mealtimes.
- Avoid carbonated beverages and juice drinks (juice drinks contain high-fructose corn syrup and <100% natural juice).
- Encourage children to drink only water and milk between meals.
- Encourage children to eat fruits.
- Limit the intake of 100% fruit juice to no more than 4 oz per day.
- Foster eating patterns that are consistent with MyPyramid guidelines from the US Department of Agriculture.[30]

Optimal Use of Fluorides

Fluoride, a naturally occurring element, has been instrumental in the widespread decrease in dental caries.[31,32] The mechanisms of fluoride are both topical and systemic, with evidence pointing to a greater topical effect.[33]

Fluoride reduces enamel dissolution while it encourages remineralization.[34] Antimicrobial effects of fluorides at low pH are also significant.[35]

The delivery of fluoride includes community-based, professionally applied, and self-administered modalities. Water fluoridation is a community-based intervention that optimizes the level of fluoride in drinking water, resulting in preeruptive and posteruptive protection of the teeth.[36] Water fluoridation is a cost-effective means of preventing dental caries, with the lifetime cost per person equaling less than the cost of 1 dental restoration.[37,38] In short, fluoridated water is the cheapest and most effective way to deliver anticaries benefits to communities.

Professionally applied topical fluorides (PATFs) have their greatest effect preventing caries and must be applied at regular intervals.[39] PATFs include gel, foam, in-office rinse, and varnish. PATFs are safe and efficacious, with varnishes having the advantage of adherence to the tooth surface, decreasing likelihood of ingestion, and increasing time of contact between the fluoride and tooth surface.[37,39] In the primary dentition, varnish effectiveness (measured by percent of caries reduction) ranges from 30% to 63.2%,[40,41] and an analysis of the number of fluoride-varnish applications received resulted in a dose-response effect that was enhanced when coupled with counseling.[42] Finally, self-administered fluorides, including dietary fluoride supplementation and fluoridated toothpaste, have proven effective, providing low but protracted elevation of fluoride concentrations.[35,43] Caries reduction associated with self-administered fluoride supplementation ranges from 32% to 72% in the primary dentition.[40] In children and adolescents, fluoride toothpastes, mouth rinses, and gels reduce dental caries to a similar extent.[44]

The decision to use fluoride therapies must balance the risk of caries against the risk of enamel fluorosis (hypomineralization of the developing enamel caused by excess fluoride ingestion). Patients determined to be at increased risk of dental caries are candidates for more aggressive fluoride therapy utilization. Caries susceptibility and sources of dietary fluoride (eg, water supplies, beverages, prepared food, toothpaste) should be considered before recommending fluoride therapies.[45–48] Enamel fluorosis develops before tooth maturation and emergence, typically in children younger than 8 years.[49] The risk of enamel fluorosis is an aesthetic concern, with very mild or mild forms most commonly observed in the general population.[2,50]

ANTICIPATORY GUIDANCE

Anticipatory guidance is the process of providing practical, developmentally appropriate information about children's health to prepare parents for significant physical, emotional, and psychological milestones.[51] Anticipatory guidance during well-child visits is an effective tool to educate parents about maintaining children's health. Mirroring the pediatric model, the American Academy of Pediatric Dentistry advocates oral health anticipatory guidance.[52–55] Anticipatory guidance focused on oral health disease should be an integral part of preventive pediatrics. Information concerning the impact of diet on dental health and counseling in regards to oral hygiene, nonnutritive oral habits, and dental safety should be shared with parents. Therefore, in addition to dietary counseling and optimizing fluoride exposure, anticipatory guidance for oral health includes:

1. Infant oral hygiene instruction: Teeth should be brushed at least twice daily with caregiver supervision and assistance for children. For children with elevated dental caries risk, consider using a pea-sized amount of toothpaste or an amount equivalent to the child's fifth-digit fingernail. Flossing should begin as soon as adjacent teeth are in contact and for surfaces at which 2 teeth touch and they can no longer be cleansed with a toothbrush.
2. Counseling regarding nonnutritive oral habits: Use of pacifiers in the first year of life may prevent sudden infant death syndrome.[56] Sucking habits (eg, pacifiers or digits) of sufficient frequency, duration, and intensity may be associated with dentoalveolar deformations. Some changes persist past cessation of the habit. Professional evaluation is indicated for nonnutritive sucking habits that continue beyond 3 years of age.[53]
3. Age-appropriate information regarding dental injury prevention: Parents should cover sharp corners of household furnishings at the level of walking toddlers, ensure use of car safety seats, and be aware of electrical cord risk for mouth injury. Properly fitted mouth guards are indicated for youths involved in sporting activities that carry a risk of orofacial injury.

Anticipatory guidance is valuable, because it emphasizes prevention of dental problems rather than surgical or restorative care. Anticipatory guidance and well-child visits during the first 2 years of life decrease the number of hospitalizations among poor and near-poor children irrespective of race and health status.[57] Oral health anticipatory guidance can reduce dental expenditures.[58] In light of this evidence, oral health anticipatory guidance should be integrated as a part of comprehensive counseling during well-child visits.[59]

INTERPROFESSIONAL COLLABORATION AND ESTABLISHMENT OF A DENTAL HOME

To be successful in preventing dental disease, interventions must begin within the first year of life. Pediatricians are well positioned to initiate preventive oral health care by providing early assessment of risk, anticipatory guidance, and timely referral to establish a dental home. The American Academy of Pediatric Dentistry, the American Dental Association, and the American Association of Public Health Dentistry recommend that infants be scheduled for an initial oral examination within 6 months of the eruption of the first primary tooth but by no later than 12 months of age.

The pediatric community promotes the concept of a medical home to improve families' care utilization, seeking appropriate and preventive services with optimal compliance to recommendations. The concept of the

dental home is based on this model and is intended to improve access to oral care. A dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.[52,60,61] A dental home should be able to provide the following:

1. an accurate risk assessment for oral diseases and conditions;
2. an individualized preventive dental health program based on risk assessment;
3. anticipatory guidance about growth and development issues (eg, maxillofacial and dentoalveolar development);
4. a plan for emergency dental trauma management;
5. information regarding care of teeth and oral soft tissues;
6. nutrition and dietary counseling;
7. comprehensive oral health care in accordance with accepted guidelines and periodicity schedules for pediatric oral health; and
8. referrals to dental specialists such as endodontists, oral surgeons, orthodontists, and periodontists when care cannot be provided directly within the dental home.

Lack of access to dental care can be a barrier to establishment of a dental home. Because of the specialized training and expertise, the dentist provides an ideal dental home; however, when a dentist is not available, the pediatric medical provider should fulfill the dictates of preventive oral health care until a dentist can be accessed and a dental home can be established. Therefore, primary care pediatric practitioners are an integral community component in the overall effort to address oral health issues (eg, access to care, preventive intervention). With the continuing challenges of access to dentistry coupled with preschool-aged children making many more visits to medical offices than to dental offices, primary care practitioners with oral health training have reported that they have provided preventive oral health services for their pediatric patients.[51,52] North Carolina primary care practitioners were able to integrate preventive dental services into their practices, increasing preventive services for young children who receive Medicaid benefits and whose access to dentists is restricted (eg, geographically or because of nonparticipation of dentists).[62] Often, the first step of timely establishment of a dental home is a referral from the physician. Although a report from the US Preventive Services Task Force on physicians' roles in preventing dental caries in preschool-aged children found referral by a primary care practitioner only partially effective in increasing dental visits,[40] another study[63] reported that dentists were more likely to see young children referred by primary care practitioners.

Primary care practitioners are able to identify children in need of a referral to a dentist.[64] After 2 hours of training in infant oral health, primary care pediatric practitioners accurately identified children with cavities with good specificity (92%–100%) and sensitivity (87%–99%).[40,63] These results suggest that dental screening can be incorporated into a busy pediatrics practice and that primary care pediatric practitioners can contribute significantly to the overall oral health of young children by encouraging parents to enroll their children in a dental home as early as possible.

In summary, the ideal setting for administration of oral health care is the dental home. When there is no access to a dentist, the pediatric medical provider should consider administering risk-based preventive oral health measures until a dental home can be made available. With preparation, primary care practitioners are routinely able to screen accurately and provide oral health anticipatory guidance for children. Furthermore, they are ideally positioned to refer children to a dental home in a timely manner. Establishing collaborative relationships between physicians and dentists at the community level is essential for increasing access to dental care for all children and improving their oral and overall health.

RECOMMENDATIONS FOR PRIMARY CARE PEDIATRIC PRACTITIONERS

1. An oral health risk assessment should be administered periodically to all children.
2. Oral health risk-assessment training should be recommended for medical practitioners who are in training programs and those who currently administer care to children.
3. Dietary counseling for optimal oral health should be an intrinsic component of general health counseling.
4. Anticipatory guidance for oral health should be an integral part of comprehensive patient counseling.
5. Administration of all fluoride modalities should be based on an individual's caries risk. Patients who have a high risk of caries are candidates for consideration of more intensive fluoride exposure after dietary counseling and oral hygiene instruction as compared with patients with a lower risk of caries (see Figs 1 and 2).
6. Supervised use of fluoride toothpaste is recommended for all children with teeth.
7. The application of fluoride varnish by the medical practitioner is appropriate for patients with significant risk of dental caries who are unable to establish a dental home.
8. Every child should have a dental home established by 1 year of age.
9. Collaborative relationships with local dentists should be established to optimize the availability of a dental home.

CONCLUSIONS

Oral health is an integral part of the overall health and well-being of children. A pediatrician who is familiar

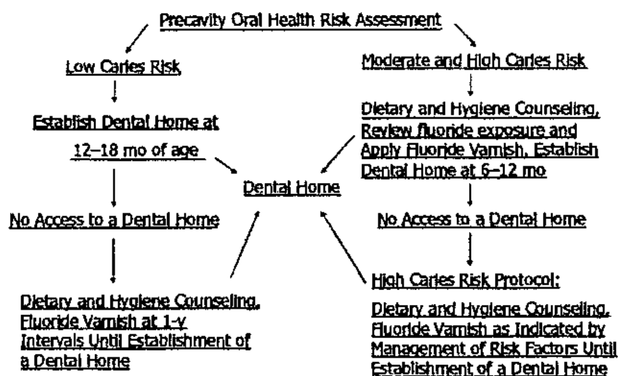

FIGURE 1
Pediatric medicine: oral health intervention algorithm.

- Appoint patient at 1-mo intervals × 3.
- Review dietary intake of sugars sources (juices, etc) at each appointment.
- Assess oral hygiene at each appointment, (plaque/inflammation).
- Review fluoride exposure and apply fluoride varnish at each appointment if risk factors persist.
- At the third 1-mo visit, if all risk factors are well managed: Reappoint at 3 mo, review diet, hygiene, fluoride exposure, and apply fluoride varnish. If risk factors are not controlled: Continue with 1-mo recalls until risk factors are managed.
- At 3-mo recall interval, if all risk factors are well managed: Reappoint every 6 mo, review diet, hygiene, fluoride exposure, and apply fluoride varnish.

FIGURE 2
High caries risk protocol.

with the science of dental caries, capable of assessing caries risk, comfortable with applying various strategies of prevention and intervention, and connected to dental resources can contribute considerably to the health of his or her patients. This policy statement, in conjunction with the oral health recommendations of the American Academy of Pediatrics *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd edition,[65] serves as a resource for pediatricians and other clinicians to be knowledgeable about addressing dental caries. With dental caries being such a common and consequential disease process in the pediatric population, it is essential that pediatricians include oral health in their daily practice of pediatrics.

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NH ORAL HEALTH COALITION

Promoting optimal oral health for the people of New Hampshire

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File HB 1537

January 12, 2010

To: NH House of Representatives
Health, Human Service and Elderly Affairs Committee

Good morning Madam Chair and distinguished committee members,

My name is Angela Boyle and I am here today on behalf of the NH Oral Health Coalition. The Coalition is made up of a broad representation of individuals, organizations and agencies concerned with oral health in NH.

This summer the Oral Health Coalition was fortunate to participate in the HB414 Study Commission to examine ways to prevent dental disease among NH's Children. We would like to applaud the committee's legislative leadership, Rep. DiPentima, Rep. Pilliod and Senator Gilmour for conducting a well organized, productive and successful study in such a short period of time. We learned through the study commission that much of the work of integrating oral health into primary care for young children has been completed such as:

- Evidence based practices have been instituted in 35 states including every New England State except for NH
- An accredited program for training the medical community exists both locally and nationally
- A funded and successful pilot project has been conducted utilizing the Family Health Center at Concord Hospital
- An existing workforce who have access to very young children and are willing to share the responsibility in preventing dental disease

It was also learned through data submitted by the NH Department of Health and Human Services that in the year 2007, 436 Medicaid children were seen in operating rooms (OR) for corrective dental care and in 2008, 547 children were admitted to the OR[1]. NH's children are in clear need of basic preventive oral health care aimed at reducing this disease. Through preventive care, states have an opportunity to better serve young children and work toward a goal of reducing state expenditures on costly restorative care.

NH Oral Health Coalition strongly supports HB1537 because it is a smart approach to establishing the remaining and necessary building blocks to improve oral health for very young children in NH. I thank you for allowing the Coalition an opportunity to emphasize how critical this bill is for NH's children.

Attached please find the 2007 CMS EPSDT Participation Report for NH and a map indicating which states reimburse physicians under Medicaid. I would be happy to answer any questions.

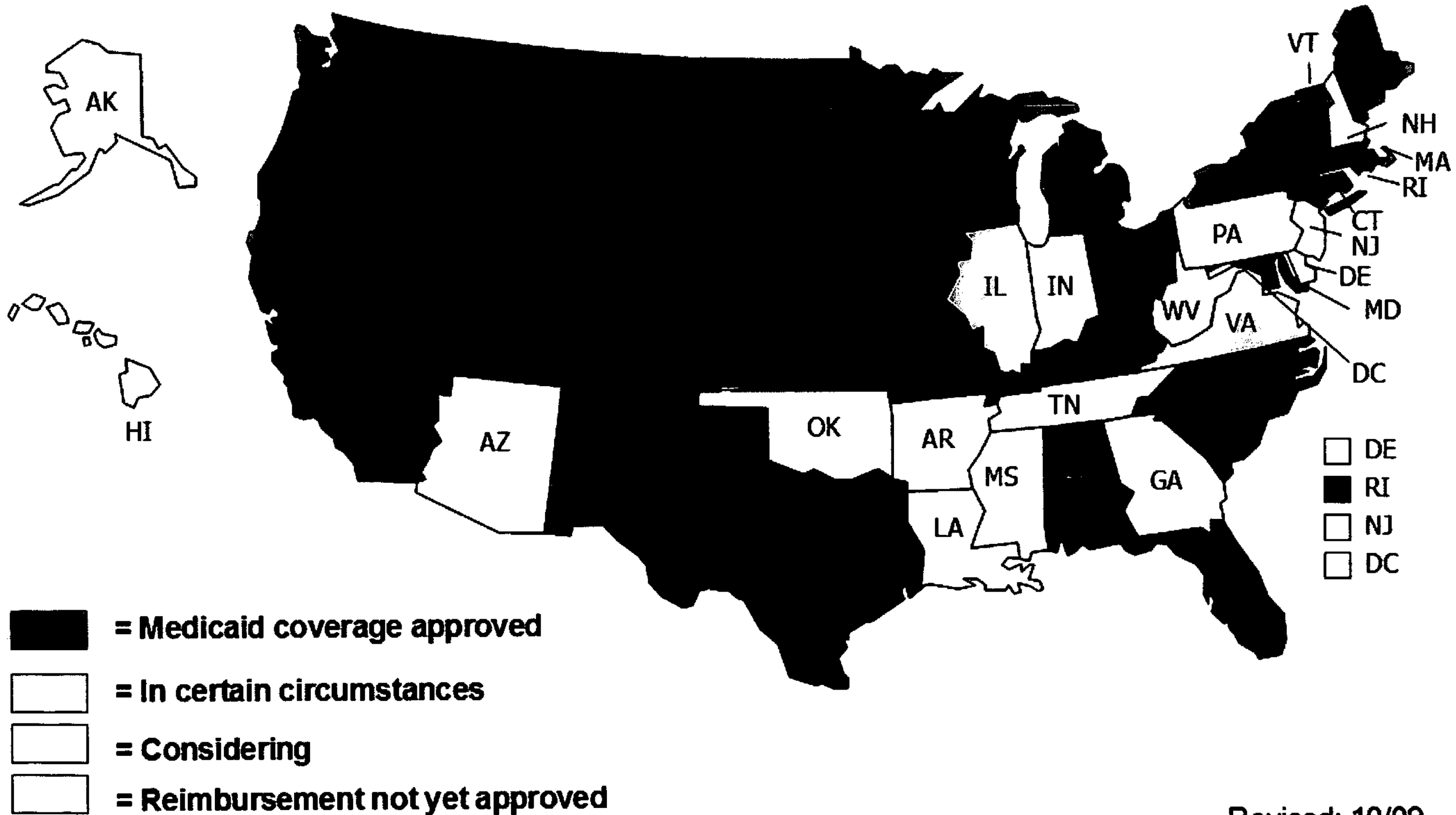
Respectfully,

Angela Boyle

Angela Boyle, RDH, BS
Director, NH Oral Health Coalition

[1] NH DHHS-OMBP-BDSM-DV 9/15/2009 Data prepared for 2009 HB#414 Study Commission

States with Medicaid Funding for Physician Oral Health Screening and Fluoride Varnish



Revised: 10/09

3/3/2009

ANNUAL EPSDT PARTICIPATION REPORT

New Hampshire FY: 2007

		CAT.	TOTAL	<1	1-2	3-5	6-9	10-14	15-18	19-20
				Age Groups						
1.	Total Individuals Eligible for EPSDT	CN	87,286	5,599	10,893	13,949	17,558	19,975	15,257	4,055
		MN	3,392	123	323	548	763	820	644	171
		TOTAL	90,678	5,722	11,216	14,497	18,321	20,795	15,901	4,226
2a.	State Periodicity Schedule			6	4	3	2	5	4	2
2b.	Number of Years in Age Group			1	2	3	4	5	4	2
2c.	Annual. State Periodicity Sched.			6.00	2.00	1.00	0.50	1.00	1.00	1.00
3A.	Total Months of Eligibility	CN	818,086	32,549	105,603	136,005	172,819	197,165	146,169	27,776
		MN	15,081	312	1,253	2,388	3,297	3,927	3,167	737
		TOTAL	833,167	32,861	106,856	138,393	176,116	201,092	149,336	28,513
3B.	Average Period of Eligibility	CN	0.78	0.48	0.81	0.81	0.82	0.82	0.80	0.57
		MN	0.37	0.21	0.32	0.36	0.36	0.40	0.41	0.36
		TOTAL	0.77	0.48	0.79	0.80	0.80	0.81	0.78	0.56
4.	Expected Number of Screenings per Eligible	CN		2.88	1.62	0.81	0.41	0.82	0.80	0.57
		MN		1.26	0.64	0.36	0.18	0.40	0.41	0.36
		TOTAL		2.88	1.58	0.80	0.40	0.81	0.78	0.56
5.	Expected Number of Screenings	CN	83,167	16,125	17,647	11,299	7,199	16,380	12,206	2,311
		MN	1,350	155	207	197	137	328	264	62
		TOTAL	84,517	16,280	17,854	11,496	7,336	16,708	12,470	2,373
6.	Total Screens Received	CN	52,564	13,733	14,665	6,172	6,049	6,758	4,506	681
		MN	675	135	140	100	90	116	78	16
		TOTAL	53,239	13,868	14,805	6,272	6,139	6,874	4,584	697
7.	Screening Ratio	CN	0.63	0.85	0.83	0.55	0.84	0.41	0.37	0.29
		MN	0.50	0.87	0.68	0.51	0.66	0.35	0.30	0.26
		TOTAL	0.63	0.85	0.83	0.55	0.84	0.41	0.37	0.29

3/3/2009

ANNUAL EPSDT PARTICIPATION REPORT
New Hampshire FY: 2007

		CAT.	TOTAL	Age Groups <1	1-2	3-5	6-9	10-14	15-18	19-20
8.	Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN	65,887	5,599	10,893	11,299	7,199	16,380	12,206	2,311
		MN	1,318	123	207	197	137	328	264	62
		TOTAL	67,205	5,722	11,100	11,496	7,336	16,708	12,470	2,373
9.	Total Eligibles Receiving at Least One Initial or Periodic Screen	CN	40,589	4,845	7,881	7,401	6,980	7,863	4,932	687
		MN	708	84	127	123	117	146	94	17
		TOTAL	41,297	4,929	8,008	7,524	7,097	8,009	5,026	704
10.	Participant Ratio	CN	0.62	0.87	0.72	0.66	0.97	0.48	0.40	0.30
		MN	0.54	0.68	0.61	0.62	0.85	0.45	0.36	0.27
		TOTAL	0.61	0.86	0.72	0.65	0.97	0.48	0.40	0.30
11.	Total Eligibles Referred for Corrective Treatment	CN	0	0	0	0	0	0	0	0
		MN	0	0	0	0	0	0	0	0
		TOTAL	0	0	0	0	0	0	0	0
12a.	Total Eligibles Receiving Any Dental Services	CN	38,205	24	1,477	6,359	10,306	11,286	7,635	1,118
		MN	905	0	27	123	239	280	203	33
		TOTAL	39,110	24	1,504	6,482	10,545	11,566	7,838	1,151
12b.	Total Eligibles Receiving Preventive Dental Srvcs.	CN	34,212	19	864	5,779	9,735	10,421	6,583	811
		MN	737	0	18	108	207	237	150	17
		TOTAL	34,949	19	882	5,887	9,942	10,658	6,733	828
12c.	Total Eligibles Receiving Dental Treatment Srvcs.	CN	17,513	1	125	1,739	4,681	5,646	4,621	700
		MN	379	0	5	38	91	110	113	22
		TOTAL	17,892	1	130	1,777	4,772	5,756	4,734	722
13.	Total Eligibles Enrolled in Managed Care	CN	0	0	0	0	0	0	0	0
		MN	0	0	0	0	0	0	0	0
		TOTAL	0	0	0	0	0	0	0	0
14.	Total Number of Screening Blood Lead Test	CN	4,701	118	3,726	857				
		MN	55	1	39	15				
		Total	4,756	119	3,765	872				

File HB 1537

HB# 414
Study Commission Findings

	CY 2007	CY 2008
Patients	436	547
Claims	449	574
Diagnosis	96% Dental Caries	98% Dental Caries
Operating Room Services	$434,787	$496,840
Anesthesia	$120,384	$146,031
Recovery Room	$37,774	$45,680
Medical Surgical Supplies	$23,020	$25,664
Pharmacy	$20,269	$19,867
Other Ancillary	$5,681	$4,115
Total Paid	**$641,915**	**$738,196**

- The CPT code was missing on most of the 2007 operating room claims and about half of the claims in 2008. When listed, the majority of the claims were submitted with CPT 41899, whose description is unspecified dental surgery.

Above Data provided by: NH DHHS-OMBP-BDSM-DV 9/15/09 at HB#414 Study Commission

Information below is a "back of the napkin" look at potential savings for integrating dental disease prevention services into pediatric well child visits

Year	Medicaid Children Seen in Operating Rooms	Estimated Dental Provider Fee @ $4,000 per child	Cost of Hospital and Ancillary Services	**Total Estimated Cost of Corrective Treatment**	Cost of Prevention Fluoride Varnish @ $50.00/year/ childx3 years	**Total Savings**
2007	436	$1,744,000	$641,915	**$2,385,915**	$65,400	**$2,320,515**
2008	547	$2,188,000	$738,196	**$2,926,196**	$82,050	**$2,844,146**
Total	983	$3,932,000	$1,380,111	**$5,312,111**	$147,450	**$5,164,661**

File HB1537
Dr. Kelly White

Talking Points for HB 1537

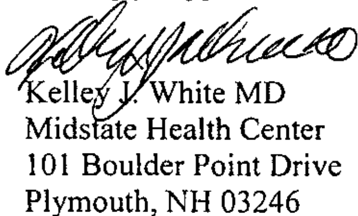
I wish to add my voice in support of HB 1537, a long-overdue effort to address the dental health needs of NH children. I speak first from personal experience—I have a typical NH mouth—fillings upon fillings on top of fillings on each and every tooth. (and I thought fillings were forever: not so, I am now in the process of extensive restorative work as my previous fillings age and fail.) I grew up in Gilford in the 1960's and clearly recall a dental hygienist coming to our elementary school to provide fluoride treatments. However, by elementary school the damage was done. Preschool care may very well have diminished or eliminated my dental problems.

I have nearly 30 years experience in primary care pediatrics in inner-city Philadelphia and joined Midstate Health Center in Plymouth in 2008 after a long desired return "home". Ironically, my impoverished inner-city patients often had fine dentition, related to an appropriate fluoride level in the city water supply. However, I saw many children with "baby-bottle tooth decay" related to sleep habits with a bottle of milk or juice basically present in the mouth constantly. Such decay is painful, disfiguring, and may require very intensive dental work; young children may require general anesthesia with its attendant significant risk for complication and even death.

I am excited by the opportunity to learn more about dental care and prevention and look forward to developing skills for oral exams in very young children. Although I have always attempted to provide information about preventive oral hygiene and good nutrition such discussion may be too brief given the multitude of issues to be discussed during a primary care visit. Gaining additional training and skills and additional office time to address this important health area will allow me, as a primary care provider to appropriately promote oral hygiene. It is difficult to find a dental home for NH children--statistics show we have very few pediatric dentists and that the lack of services worsens as one moves from south to north in our state. Midstate, as a community health center, is dedicated to providing a medical home for families. Surely this care should include oral heatlh.

However, for PCPs to develop new skills, learn more about oral health, increase time for office visits (allowing the clinician to see fewer patients per day) and to provide for staff training, screening tools, and fluoride varnish supplies will require reimbursement at an appropriate and fair level.

I strongly support HB 1537 as much needed by the children of our proud state.



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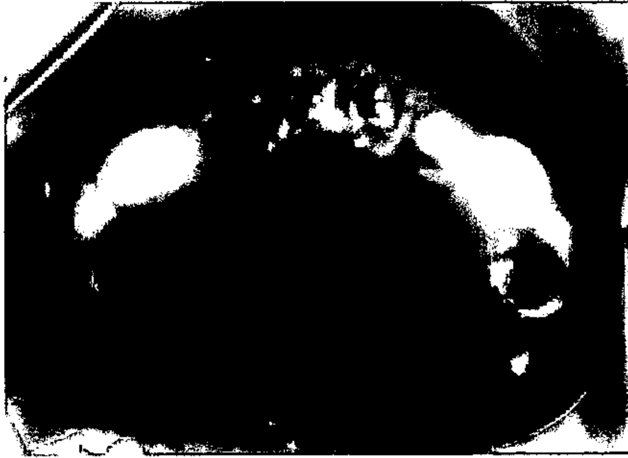
Midstate Health Center
101 Boulder Point Drive
Plymouth, NH 03246

File HB 1537
Dr. Kelly White



File HB 1537

Integrating Oral Health into Primary Care: Early Childhood 0 – 5 Years Old: Program Fact Sheet

Submitted by: Paula Smith, Director, and Malone Cloitre, Program Coordinator, Southern NH AHEC

MISSION: The Southern NH Area Health Education Center develops, promotes and coordinates community and academic multidisciplinary partnerships for health profession education. Your community AHEC focuses on underserved communities and provides education and training opportunities for students, practicing health professionals and members of Southern NH communities. One way we accomplish our mission is by providing continuing education to health care workers. Southern NH AHEC is an approved provider of continuing nursing education by the New Hampshire Nurses' Association Commission on Continuing Education (NHNACCE), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation and is also accredited by the New Hampshire Medical Society (NHMS) to provide continuing medical education for physicians. We work with other professional groups such as NH Dental Society to provide other types of credit when appropriate.

Integrating Oral Health Into Primary Care: Early Childhood 0 – 5 Years Old Program Description:
This program was a 2nd generation program. The first generation focused on pregnant women. This program as initiated through the State Oral Health Collaborative Systems Grant which operated for 3 years from 2004 – 2007 and continued through 2009 with grants from Community Health Access Network and Northeast Delta Dental.

Learning Objectives

- Describe importance of risk assessment and strategies for implementation in a busy practice.
- Identify options for providing fluoride.
- Demonstrate proper screening techniques.
- Discuss anticipatory guidance in relation to the periodicity chart.

Stakeholders and Planning Committee:

- Margaret Snow, DMD, MBA, MPH, FICD, Dental Director, Dept. of Health & Human Service, Medicaid
- Nancy Martin, RDH, MS, Oral Health Program Manager, Dept. of Health & Human Services
- Hope Saltmarsh, RDH, M.Ed, consultant & educator
- Paula Smith, MBA, Director, SNHAHEC
- Malone Cloitre, Program Coordinator, SNHAHEC
- Ashley Grill, RDH, MPH, consultant & educator
- Russell Jones, MD
- Lucinda Colburn, RDH, consultant & educator
- NH Minority Health Coalition
- American Academy of Pediatric : curriculum content

Prior Knowledge:

- Dental workforce shortage
- 18 Pediatric dentists practicing in the state.
- 80% of disease is in 20% of the population
- The population most at risk goes to well child visits but not their dental appointments.
- There are approximate 12 well child visits from birth to 3 years old.

Year 1

- Completed a national & statewide literature search for consumer and provider oral health educational materials.
- Regional focus groups with health care providers (medical & dental) along with online survey.
- High risk consumer focus group (partnership with New Hampshire Minority Health Coalition).
- Development of Patient Education handout.

- Curriculum development for medical practices for Lunch & Learn model. This includes written & clinical risk assessment tools.
- Development of Resource packet given to all clinical staff during presentation.

Year 2

- Brochure Development
- Marketing to Primary Care Practices, Community Health centers, and Pediatric Practices

Year 3

- Broaden marketing to people who come into contact with children 0 – 5 years old: Maternal Child Health Coordinators, Child Care Centers via Child Care Resource and Referral Network, Home Visiting Nurses, WIC and Head Start

Year 4

- Funding received from CHAN and NE Delta Dental

Results after 4 years

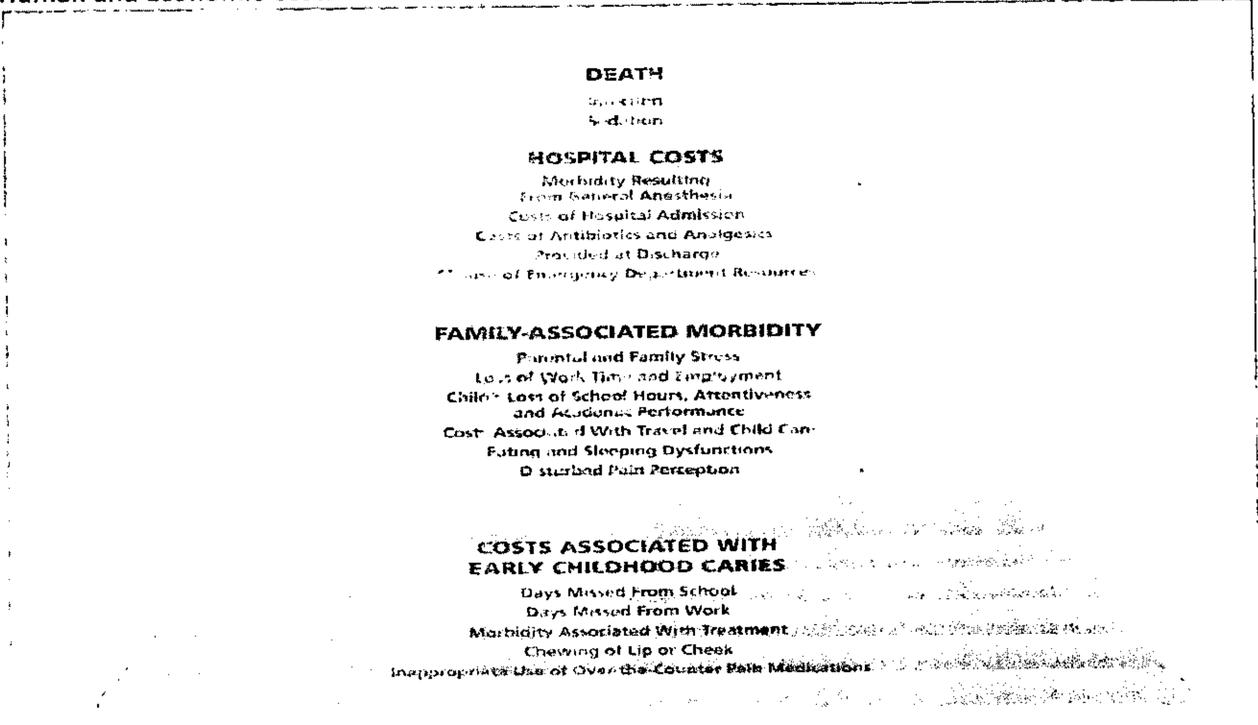
- 39 Lunch and Learn presentations
- Educated 512 health professionals
- Educated 77 providers (MD & NP)
- 30 sites: primary care, child care centers, head start and WIC

Evaluation

- Evaluation forms collecting knowledge before and after were completed after every lunch and learn presentation.
- Comprehensive 3rd year evaluation done of evaluation form summaries and phone interviews.

The comprehensive evaluation performed by NH Minority Health Coalition

Human and Economic Cost:



Graph from: Paul S. Casamassimo, Sarat Thikkurissy, Burton L. Edelstein and Elyse Maiorini, "Beyond the dmft: The Human and Economic Cost of Early Childhood Caries", The Journal of the American Dental Association, 2009;140;650-657

There are human and economic costs to early childhood caries. In our testimony that we are submitting, we use a chart from a recent article that describes the progression of cost. The human costs can been seen in a child's failure to thrive and failure to smile and as in the case of Deamonte Drive it can lead to death. The economic cost start with missed days of work and can lead to cost of hospitalization. Deamonte Drive's hospital totaled approximately $250,000 to try to save his life.

In closing, we support HB 1537. Primary care providers are well positioned to provide preventive oral health care to children 0 to 3 years of age. As mentioned earlier 80% of the disease is in 20% of the population which means our safety net providers are crucial in providing this care. This bill cannot become an unfunded mandate. As a preventive health care measure, adequate reimbursement is required which will be leveraged in future years when less restorative care is needed.

For further questions please contact: Paula Smith, Director, Southern NH AHEC, Tel. (603) 895-1514 ext. 1, Email: psmith@snhahec.org

File
HB 1537

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Written Testimony of NH Healthy Kids Corporation
Gail M. Garceau, President and CEO
IN SUPPORT OF House Bill 1537
Before the Health, Human Services and Elderly Affairs Committee
January 12, 2010

NH Healthy Kids Corporation (NHHK) supports the concept of House Bill 1537 to permit primary care providers to deliver preventive oral health services to children in accordance with our philosophy to promote healthy lifestyles, encourage preventive health and dental care, treat illness early and manage chronic health conditions. On behalf of the New Hampshire Healthy Kids Silver population, New Hampshire Healthy Kids would like to request that those covered under our Silver program be included in any action on this Bill that would assist in expanding access to necessary dental services. Our partner, Northeast Delta Dental, has already considered this initiative, and we believe these services can be provided to the New Hampshire Healthy Kids Silver population at no additional costs, presuming we receive federal approval.

Under a contractual partnership with the New Hampshire Department of Health & Human Services, NHHK leads the effort to educate the public about children's health coverage options and to assist families in applying for coverage. NHHK directly administers the premium-based SCHIP/Title XXI program through insurance subcontracts with Harvard Pilgrim Health Care and Northeast Delta Dental, covering approximately 8,047 of New Hampshire's children. In addition, our headquarters in Concord serves as the mail-in application and enrollment center for both Medicaid and SCHIP, known as Healthy Kids Gold and Silver respectively.

NH Healthy Kids' vision is for every child to go to school healthy and ready to learn. We support broader oral health care access for Medicaid and SCHIP enrollees and value early intervention and preventive care. It has been proven that oral health is integral to the overall health and well-being of children. In a 2000 report, "the U.S. Surgeon General stated that oral health is a key determining factor in the condition of a child's overall health".[1]

According to the Healthy Smiles Healthy Children Foundation of the American Academy of Pediatric Dentistry 2009 Annual Report,

- *Over 40%-50% of children will be affected by tooth decay by the age of 5*
- *Of the 4 million children born each year, more than half will have cavities by the time they reach second grade*

[1] National Academy for State Health Policy, *Briefing: Engaging Primary Care Medical Providers in Children's Oral Health*, Chris Cantrell, September 2009

- *According to the May 2000 Surgeon General's report, Oral Health in America, more than 51 million school hours are lost each year to dental-related conditions*[2]

New Hampshire has consistently proved to be a pioneer in covering kids and providing outstanding medical and dental coverage in Medicaid and SCHIP. With regard to permitting primary care providers to deliver preventive oral health services to children, New Hampshire has fallen behind. Two-thirds of the nation's Medicaid programs have already implemented these screenings with proven success. New Hampshire is the only state in New England not providing this service.

There are thousands of children in New Hampshire without health and dental insurance. While NH Healthy Kids works to reach those children, it is imperative that we ensure that the 75,415 enrolled in Healthy Kids Gold and 8,047 enrolled in Healthy Kids Silver receive quality preventive medical and dental care. HB 1537 is a step in the right direction to expand the access New Hampshire's most vulnerable population has to receiving timely and effective oral health services.

NH Healthy Kids supports the concept of House Bill 1537 and seeks to have Healthy Kids Silver members included in a State Plan Amendment where appropriate. Thank you in advance for your consideration.

[2] Healthy Smiles Healthy Children; The Foundation of the American Academy of Pediatric Dentistry. (2010). *2009 Annual Report.* Retrieved from http://www.aapd.org/foundation/pdfs/2009/HSHC2009AnnualReport.pdf

File
HB 1537

Testimony – HB 1537
January 12, 2010

My name is Lindsay Josephs. I'm here today representing the Endowment for Health where I served as the Oral Health Program Director for the past 9 years, and speaking in support of House Bill 1537. As you may know, the Endowment for Health is a statewide private foundation whose mission it is to improve the health and reduce the burden of illness for the people of NH, especially those who are most vulnerable and underserved.

In our organizing year of 2001, our Board and Advisory Committee chose ORAL HEALTH and ACCESS TO HEALTH AND HEALTH CARE (DEFINED AS INCLUDING ORAL HEALTH) as our top 2 priorities. We chose oral health for several reasons including:

- the overwhelming, unaddressed oral health need in NH at the time
- the growing body of scientific evidence linking oral health to overall health,
- and the evolution of new, evidence based best practices that focused on disease prevention through the integration of oral health with primary care

Since 2001, the Endowment has invested almost $6,000,000 and awarded approximately 70 grants related to oral health, ranging from WYM, the multi-state public awareness campaign, to working in partnership with the NH DHHS on the creation of the state's first ever ORAL HEALTH PLAN, to piloting a variety of community and school based dental programs and dental centers aimed at increasing access to preventive and restorative services. Many dollars were invested in information gathering and data dissemination on the oral health status of NH residents, the adequacy of available workforce, and access to care at the local, regional, and statewide level, as well as the creation of new points of access for the low income and underserved and support for the NH Oral Coalition.

As many as six years ago the Endowment's funding strategy included assuring that medical providers were aware of and trained in evidence-based prevention practices that encouraged and supported the integration of oral health in the care of young children up to the age of three including an oral health risk assessment, parent education, anticipatory guidance, and the routine application of fluoride varnish - the same prevention activities identified in HB 1537. While we have been slow to recognize the cost efficiency and effectiveness of these practices in New Hampshire the Endowment for Health feels hopeful today that we are ready to join the 36 other forward thinking states who currently reimburse primary care providers for these early interventions in the care of their young patients.

The Commission that was established through HB 414 to study childhood dental disease in NH and to make recommendations for positive change is to be congratulated. The Commission's report serves as the foundation on which HB 1537 was created and provides an excellent and very detailed analysis of the problem, the scientific research that has been conducted nationally, the evidence based conclusions of that research, and the best practice models that have been developed and employed in response. Simultaneous to the Commission's study, NH DHHS conducted a survey of its own specific to the oral health and body mass index of NH's 3rd grade students – The Healthy Smiles-Healthy Growth Survey. The findings of the Department's study support the findings and recommendations contained in the Commission's Report.

The Department's survey found that, overall, 43.6% of NH's third graders have a history of tooth decay. When the Department looked further and stratified the prevalence of tooth decay by the % of children eligible for free or reduced lunch they found that in schools where more than half the students benefited from the free and reduced lunch **68%** of them had a history of decay. 22% had untreated decay and required early or urgent treatment. Compare this to children in schools where less than 25% were eligible for free and reduced lunch and the

percentage with a history of decay dropped to 38.5% and only 9.7% required treatment. Equally disturbing are the findings in another study conducted by the Department in 2008. This study documented that among low income, Medicaid eligible children between the ages of three and five attending HeadStart, 40% **already** had a history of tooth decay, 30% had untreated decay, and 22% required treatment. The socio-economics of oral health and access to treatment seem clear in these statistics.

HB 1537 authorizes DHHS to reimburse pediatric and family physicians for services that will help prevent tooth decay and poor oral health in children covered under the state Medicaid program. Because, as both the Commission and DHHS studies have cited, these low income children have the highest rates of decay it makes sense that they be the first to benefit from preventive efforts offered at the time of the well child visit. Young children are routinely seen 12 or more times by their physician in the first three years of life for immunizations, assessment of growth and developmental milestones, nutritional counseling and anticipatory guidance. It makes eminent sense to utilize those same well child visits to protect them from tooth decay and the pain and suffering that often accompanies it. We know that over 95% of NH's children are properly immunized at their well child visits. Why wouldn't we give them the same advantage by protecting them from tooth decay just as they are protected from measles, mumps, rubella, pneumonia, and meningitis???

I cannot tell you how strongly the EFH feels that HB 1537 supports doing the right thing, for the right reasons, and at the right time in a child's life. Integrating and reimbursing preventive oral health services during the well child visit is an efficient and effective course of action - it captures children where they are and at an age when their healthy, new primary teeth are just emerging. Utilizing the medical home for assessing high risk children, routinely applying a protective coating of fluoride varnish, educating parents, and referring young children to a dental home **before** tooth decay occurs strengthens the relationship between

doctors and dentists and fosters a better understanding on the part of families that oral health plays a critical role in overall health now and in the future.

In conclusion, the science, the best practices, the public awareness, the opportunity to improve the economic impact on parents, children, and the Medicaid program are all present. The question now is whether NH like 36 other states, including all of our neighboring New England states, has the political will to move forward and implement change not only in the way care is delivered but how it is reimbursed.

File HB1537

January 12, 2010

HB 1537, allowing primary care providers to provide preventive oral health services to children under the state Medicaid program

Hello, my name is Ellen Legg and I am a Registered Dental Hygienist. On behalf of

NHDHA, representing the state's 1571 licensed dental hygienists,I am proud to support this legislation, which will implement a major goal of the HB 414 study on preventing dental disease among New Hampshire's children:

> **Goal: Oral health will be part of general medical care for young children**
>
> *Oral health should be incorporated into the routine primary care services provided to children. The NH Medical Society, the NH Dental Society, The NH Dental Hygiene Association and the NH Nurses Association should provide continuing education programs to encourage this practice.*

NHDHA was a member of the HB 414 study commission – our representative, Ginny Barunas, has a wealth of experience working with very young children in HeadStart and in other early childhood programs.

Data we provided to the study commission pointed up these facts:

- Tooth decay, or dental caries, is 5 times more prevalent than asthma among children
- Children are not born with decay-causing bacteria in their mouths – they are infected some time in their early life
- Bacteria is usually passed from mother or caregiver to child
- Prenatal visits are an opportune time to discuss oral health with mothers to be
- Two is too late: providing dental hygiene care along with licensed and trained pediatric providers makes sense because they see infants, young children and their caregivers many times in the first two years of life
- At-risk children can have advanced tooth decay by age 3

Primary care licensed and trained medical professionals can provide oral health screenings, prescriptive fluoride varnish and oral disease preventive information.

Dental Hygienists that are supervised by physicians and dentists can perform procedures without a dentist present in community health centers, clinics, schools, nursing homes and practices that serve large numbers of low-income patients.

NHDHA strongly supports HB 1537 as another means of increasing access to quality oral healthcare with the provision that adequate training of licensed providers regarding oral health and preventive procedures is completed and monitored for safety and outcome by the appropriate agency.

File HB1537

Breathe™
NEW HAMPSHIRE
Improving lung health since 1916

January 12, 2010

Testimony
Breathe New Hampshire
HB 1537 –AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program

Dear Chairman Rosenwald and Committee Members:

I want to thank you for allowing Breathe New Hampshire to provide testimony in support of HB 1537, a bill which would train and allow primary care providers to perform much needed dental screenings and fluoride treatments for children on Medicaid. Throughout recent years the research increasingly shows that good chronic disease management must include good oral health care. This is especially true for children with asthma and other chronic disease conditions.

Breathe New Hampshire is a local organization and our mission is to ensure that everyone in New Hampshire takes the healthiest breath possible through prevention and good management of lung disease. At Breathe New Hampshire one of our core functions is to work with parents and teachers to educate them on how to best care for children with asthma. Part of that care includes the ability to effectively manage asthma by including good preventive dental care. The types of oral medicines that are prescribed for asthma may put children at risk for dental problems because these children can have drier mouths. Dry mouths can increase the risk of dental cavities because of decreased production of protective saliva in the mouth.

According to a study by C.F. Salinas, Opala and Hardin of the Medical University of South Carolina entitled "Caries Experience in Children with Asthma" they note that children with asthma have significantly higher rates for decayed, missing and filled teeth for both their primary and permanent teeth. The significant number of children with asthma who are on Medicaid and are taking asthma medications points to the need for more aggressive dental prevention protocols as soon as a diagnosis of asthma is made. Allowing these childrens' primary care provider to perform fluoride treatments will protect this vulnerable population and is a vital component to good disease management. It also provides the most expedient time between a diagnosis of asthma and the ability to protect children's teeth prior to the administration of oral inhaled medications.

Thank you for allowing Breathe New Hampshire to provide support for this bill. If you need further information regarding the health concerns surrounding idling feel free to contact Marie Mulroy (mmulroy@breathenh.org) at 669-2411.

9 Cedarwood Dr., Unit 12 | Bedford, NH 03110 | phone 603.669.2411 | fax 603.645.6220 | www.breathenh.org
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File
HB1537

NHDHA TALKING POINTS on HB 1537

allowing primary care providers to provide preventive oral health services to children under the state Medicaid program

January 12, 2010

The NH Dental Hygienists' Association (NHDHA), representing the state's 1571 licensed dental hygienists, is proud to support this legislation, which will implement a simple but critical goal: **Oral health will be part of general medical care for young children.**

HB 1537 will require the NH Department of Health and Human Services to submit an amendment to the state Medicaid plan that will authorize primary care providers to deliver preventative oral health services to children under the state Medicaid program.

Primary care providers who choose to participate in the program will be required to complete training approved by DHHS, and then submit evidence they have completed the program to the NH Medical Society, which will then maintain a list of certified providers.

NHDHA was a member of the HB 414 study commission that developed HB 1537. Our representative, Ginny Barunas, has a wealth of experience working with very young children in HeadStart and in other early childhood programs. Her participation and data our Association provided to the HB 414 study commission pointed up these facts:

- Tooth decay, or dental caries, is **5 times more prevalent than asthma** among children
- Children are not born with decay-causing bacteria in their mouths – they are infected some time in their early life
- Bacteria is usually passed from mother or caregiver to child
- Prenatal visits are an opportune time to discuss oral health with mothers to be
- Two is too late – very young children need to be checked for tooth decay
- At-risk children can have advanced tooth decay by age 3

This bill will allow primary care medical professionals to provide oral health risk assessments and evaluations, dental screenings and fluoride varnish treatments, and patient and parent information. Providing dental hygiene care along with pediatric visits makes sense because infants, young children, and their caregivers see primary care physicians many times in the first two years of life.

NHDHA strongly supports HB 1537 as another means of increasing access to quality oral healthcare to all NH citizens, no matter what their age, geographic location, or economic status.

File HB 1537 Did not testify

NEW HAMPSHIRE MEDICAL SOCIETY

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LAY MEMBER
Martin Gross, Esq.

January 5, 2010

The NH Medical Society supports the passage of HB1537. We feel it is essential to the well being of NH's children and adolescents. This bill helps us get one step closer to integrating oral health as part of overall health.

The American Academy of Family Physicians and American Academy of Pediatrics also feel that it is an integral part of primary care to assess the dental health in their pediatric patients and prevent further disease:

"Promoting appropriate use of topical and systemic fluoride and providing early oral hygiene instruction can help reduce caries in young patients, as can regularly counseling parents to limit their child's consumption of sugar. (Am Fam Physician 2004;70:2113–20,2121–2. Copyright© 2004 American Academy of Family Physicians.)"

"Oral health is an integral part of the overall health of children. Dental caries is a common and chronic disease process with significant consequences. As health care professionals responsible for the overall health of children, pediatricians frequently confront morbidity associated with dental caries. Because caries is a non-classic infectious process (arising from shifts in subpopulation ratios of established normal flora), pediatricians have an opportunity to prevent, intervene, and, in collaboration with dental colleagues, manage this disease." *AAP Policy Statement*

The NH Medical Society is available as a resource to help answer any questions you may have.

Best regards,

Catrina Watson
NHMS

File HB1537

an exeter health resource | The Art of Wellness

January 8, 2010

House Health, Human Services and Elderly Affairs Committee

Representative Cindy Rosenwald, Chair

NH State House

RE: HB 1537

Dear Committee members and Representative Rosenwald,

We are writing to urge passage of HB 1537. This bill would greatly improve the dental care for children in our state. The bill provides a means whereby children who are covered by Medicaid can receive preventive dental services from their primary care providers. Both education for the providers and funding for treatment are addressed in the bill. If passed and fully implemented, this bill would enable doctors and nurse practitioners to continue and expand the services already being provided to keep children's teeth healthy.

We are all practicing pediatricians or nurse practitioners in the seacoast where, just as in any area of New Hampshire, a child's first dental home is also his or her medical home. The vast majority of children under the age of 3 have their developing teeth examined not by a dentist but by a primary care provider, which may be a pediatrician, family practitioner or nurse practitioner. Advice to parents about how to keep their children's teeth healthy is something we are all familiar with because it is part of the preventive care we provide to our patients. HB 1537 would enable us to learn additional ways to care for children's teeth and would allow us to be compensated by the Medicaid program for these important services. The ounce of prevention we provide to children today will translate into significant cost savings for the Medicaid program in the future. There are limited numbers of pediatric dentists across the state, so having additional providers available to help address the health of children's teeth will mean that thousands of children who are getting no dental care today will be able to access that care in the future.

Please support HB 1537. It is a wise investment in the dental future of many of New Hampshire's children.

Yours sincerely,

Wendy Gladstone, MD

Kristen Johnson, MD

Jennifer Jones, MD

Steven Loh, MD

Lori Mcclure, ARNP

Thomas Oxnard, MD

Greg Prazar, MD

Martha T Fountain MD

Everett Lamm, MD

EILEEN GRANAHAN, MD

Mark E Covey MD

ANDY WESTINGHOUSE MD

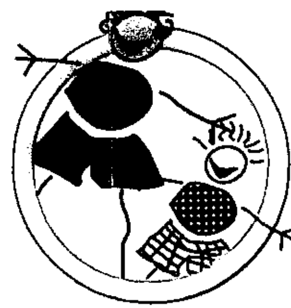
Janice Michaud, APRN

JOANN GATES

Elizabeth Melendy, MD

National Oral Health Policy Center

TRENDNOTES



File NB 537

Better Health at Lower Costs:
Policy Options for Managing Childhood Tooth Decay

October 2009

Inside this TrendNote...

Trend:

- Tooth decay is the #1 chronic condition of childhood and is on the rise among young children for the first time in 40 years.
- Cavities are the outcome of an infectious and transmissible disease called dental caries that is preventable early in life and can be manageable without expensive interventions.
- Children who experience chronic tooth decay and related pain and infection can suffer from inadequate growth and development, speech problems, lost school days, poor self-esteem, unhealthy adult teeth and high costs for dental treatment throughout life.
- Most children experience little risk for dental caries and few cavities; however, low-income and minority children experience the highest rates of dental caries and the lowest rates of dental care.
- Dental expenditures for children reflect high costs for two sub-populations: 1. a small group of children who need extensive care for the most severe consequences of dental caries; and 2. a large number of children who receive regular preventive care despite being at low risk for developing cavities.

Policy Solution:

- Support community-wide, evidence-based policies that promote children's oral health and prevent dental caries while targeting intensive intervention to those children at highest risk for the disease.

Please read on for more background information and specific policy options...

TRENDNOTES About TrendNotes

TrendNotes, published by The National Oral Health Policy Center at Children's Dental Health Project, is designed to highlight emerging trends in children's oral health and promote policies and programmatic solutions that are grounded in evidence-based research and practice. This issue of TrendNotes underscores the significance of preventing and managing childhood tooth decay – why it is imperative, what we know works, and why policymakers might want to realign policies and programs to be more consistent with this goal. It focuses policymakers' attention on the trends, opportunities and options to improve oral health for all children at lower cost through the best use of prevention, disease management, care coordination, and maximized resources.

State policymakers are increasingly focusing on children's oral health as a major policy issue, spurred in part by the 2000 U.S. Surgeon General's Report on Oral Health, the high profile death of a child from consequences of a preventable dental infection, and expanded dental provisions in the reauthorization of the Children's Health Insurance Program (CHIP). This heightened focus on children's oral health is reflected in new legislation, press coverage, and efforts by state and local oral health coalitions to advance improvements in children's oral health policies and programs. Policy activity has resulted in both successes and frustrations as oral health competes for scarce resources and the costs of both appropriate and inappropriate dental care continue to escalate. Efforts to reform health care present a significant opportunity to address the resurgence of childhood tooth decay among key populations of children.

Children's Oral Health Matters

Children's oral health is essential to child development and optimal overall health and wellbeing – a critical part of achieving key developmental milestones and function including eating, speaking, and attaining normal social and emotional development. Tooth decay, despite being preventable, remains the single most common chronic disease of U.S. children, affecting 26% of preschoolers, 44% of Kindergarteners, and more than half of teens.[1] Low-income and minority children are particularly affected as they experience the highest rates of this disease yet have the lowest rates of dental care.

Poor oral health can have significant effects on overall health, particularly in adulthood, and has been associated with heart and lung diseases, stroke, and low weight births.[2] In fact, the legacy of poor oral health in childhood is reflected in the health of young people entering the military. The Department of Defense reports that 42% of new Army recruits could not be deployed until their dental problems were addressed.[3]

Dental Caries is a Chronic Disease that is Preventable and Manageable

Dental caries – the disease process that causes cavities – is largely preventable, highly manageable, and chronic. It is a complex disease process involving the interplay of diet, fluoride, and genetics that results in individual levels of risk for cavities.[4] A family history of dental caries, lack of appropriate fluoride exposure, and frequent sugar intake are among the key risk factors for tooth decay. (See the text box: *The Disease Basics of Childhood Dental Caries.*)

Dental caries is typically established in the first few years of a child's life, with teeth being potentially susceptible to decay soon after they first appear. The occurrence of tooth decay before the age of six years – known as Early Childhood Caries (ECC) – is of particular concern because past caries experience, including having cavities in childhood, is the best predictor of tooth decay across the lifespan.[5]

Children's oral health cannot be addressed without considering the fundamental social determinants of health – the conditions in which people are born, grow, live, work and age, including the health system – that are shaped by the distribution of resources at the global, national and local levels and are mostly responsible for health inequities, according to the World Health Organization.

Public Health Interventions Focused on Prevention Can be Cost Saving

The decline in dental caries among children has mainly been due to successful, well-established public health strategies that include community water fluoridation, dental sealant programs, and public education and awareness campaigns. Long-standing, community-based public health strategies also have been successful in providing a return on public investment for those who are at the greatest risk.

- Dental costs for children enrolled in Medicaid for five continuous years who have their first preventive dental visit by age one are nearly 40% less ($263 compared to $447) than for children who receive their first dental visit after age one.[6]
- For every $1 invested in community water fluoridation $38 in dental treatment costs is saved.[7]
- School-based dental sealant programs save costs when they are delivered to children at high-risk for tooth decay.[8]

The Disease Basics of Childhood Dental Caries

Dental caries is a chronic, infectious disease caused by bacteria that are found in the mouth and transmissible from caretakers, particularly mothers, to children. When sugar and other complex carbohydrates are consumed, the bacteria produce acid that removes protective minerals (enamel) from the surface of the tooth (demineralization). If left undisturbed because of poor oral hygiene practices in combination with significant and frequent sugar intake, the bacteria can increase and over time, cause a cavity to form. In fact, the frequency of sugar intake not only feeds the cavity process but furthers the growth of decay-causing bacteria. The progression of dental caries depends on the balance of protective factors (e.g., saliva, fluoride) and disease factors in the mouth.

Dental caries is preventable and with appropriate early intervention and ongoing management, can actually be reversed. Preventive measures such as fluoride and dental sealants can prevent tooth decay. Fluoride reduces the ability of the bacteria to produce acid and promotes the remineralization of enamel, thereby preventing a cavity from continuing to form. Dental sealants are protective coatings applied to the chewing surfaces of teeth, typically in school-age children, to prevent tooth decay.

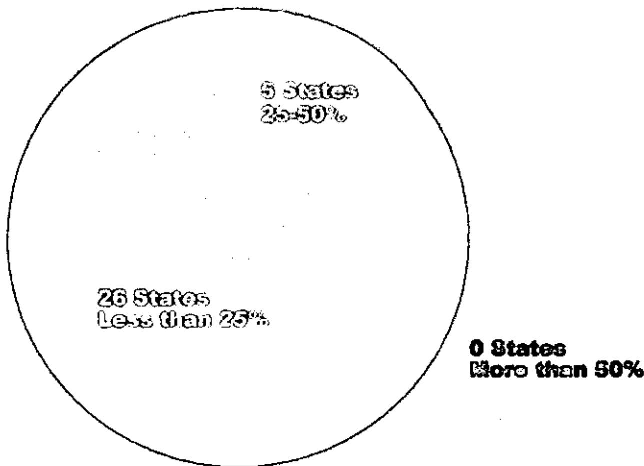
Sources. Exactly what is "Dental Caries"? Building a Definition from Research. Washington, DC. Children's Dental Health Project. Morbidity and Mortality Weekly Report. Recommendations for using fluoride to prevent and control dental caries in the United States. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. August 17, 2001/50(RR14);1-42.

Many Children Lack Access to Dental Care

Parental awareness, public and private dental coverage, and availability of dental providers, especially for children in Medicaid, are critical factors in children obtaining needed dental care. Even though children enrolled in Medicaid are individually entitled under the law to comprehensive preventive and restorative dental services, dental care utilization for this population is low. The reasons for low utilization are many, but a lack of dental providers who participate in Medicaid is a key factor.[9]

Few dentists participate in Medicaid – less than as half of all active private dentists in some areas.[10] Low reimbursement rates, complex forms and burdensome administrative requirements are commonly cited by dentists as reasons for not participating in Medicaid.[11, 12]

Percentage of Dentists Seeing at Least 100 Medicaid patients in 31 States, 1999



Source: U.S. General AccountabClty Office. Factors Contributing to Low Use of Dental Services by Low-income Populations. Washington, DC: U.S. General Accountability Office. 2000.

While children with private insurance coverage are more likely to obtain needed dental care than their counterparts, significant barriers still exist for this group. Private dental insurance coverage is often limited in scope, causing many families to pay high out-of-pocket costs for dental care.[13] In research of families that have experienced barriers to dental care, the inability to afford dental care was cited by over half (56%) of families. Among those families, 45% had private insurance coverage.[14, 15]

When children lack dental coverage and access to regular check-ups, dental care frequently waits until symptoms such as a toothache are severe and facial abscesses occur. In these cases, care is often sought in an emergency department where it is costly and likely to be limited to treating the immediate symptoms but not the underlying problem. In a recent California study, the number of emergency department visits for preventable dental conditions in children and adults grew at a rate higher than visits for diabetes.[16] Nearly a quarter of those with private health insurance used an emergency department for care. Most of the California children who presented in the emergency department for preventable dental conditions were young children ages 0-5.[17]

Opportunities to Address Dental Caries under CHIP Reauthorization Act (CHIPRA)

On February 4, 2009, President Obama signed into law the reauthorization of the Children's Health Insurance Program (CHIP). Included in the bill are eight major dental provisions that range from mandating dental coverage to encouraging primary preventive care. The new CHIP provisions include the following:

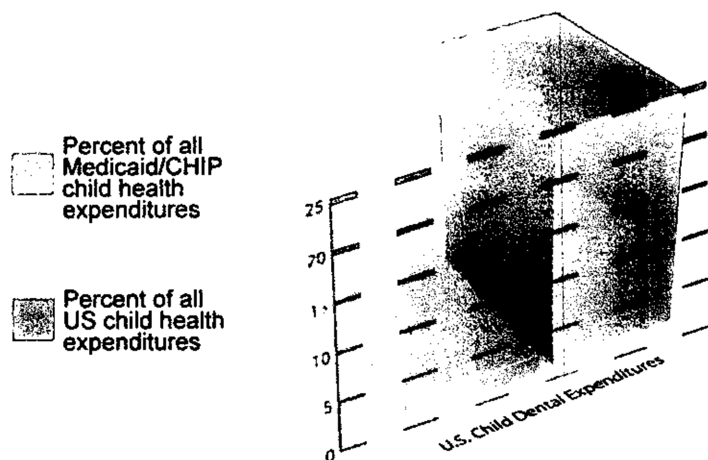
- Requires that states provide dental coverage for CHIP beneficiaries.
- Allows states to provide dental coverage that "wraps" around commercial medical coverage for children who are otherwise eligible for CHIP however they have private medical, but no dental insurance.
- Requires that states report on CHIP dental program performance.
- Establishes a requirement that parents of newborns be informed of risks for early childhood caries and its prevention.

Source and for more information: CHIP Reauthorization: Renewed Support for Children's Oral Health. Washington, DC: Children's Dental Health Project. March 2009. http://www.cdhp.org/downloads/2009%de_CHIP%20Reauthorization%202.09.pdf

Tooth Decay Results in Significant Costs to Children, Families and the Health Care System

The personal, societal and financial costs of tooth decay are significant. In the most severe cases, Early Childhood Caries and its treatment have been associated with disability and even death.[18] Annual costs for dental services (all ages) were $95.3 billion in 2007[19] and are expected to increase in the next decade to $152.6 billion.[20] Current dental expenditures constitute nearly a quarter (25%–27%) of total health care spending for children in the U.S. However, dental care represents only one-tenth that level (2%-3%) in Medicaid spending for children who comprise more than one-quarter of the U.S. child population.[21]

U.S. Child Dental Expenditures



Dental expenditures for children reflect high costs for two sub-populations: 1. a small minority of children who experience severe early childhood caries and require treatment in the hospital operating room; and 2. a large number of children who receive regular preventive care despite being at low risk for developing cavities.[22] Advanced restorative dental care needed by roughly 15% of children and "catastrophic" care needed for 5% of children are estimated to consume 75% of all pediatric dental expenditures among low-income children.[23] Because children with ECC continue to be at high risk for cavities even after dental repair and because dental repair *per se* does not diminish underlying caries activity, relapse rates are extreme, ranging to over 50 percent.[24]

Most children experience little risk for dental caries and few cavities. However, a minority of children experience high risk and extreme and consequential disease. As childhood caries experience becomes increasingly concentrated in an ever smaller percentage of children, dental experts have called for "risk-based" preventive interventions, including individually-tailored preventive visit frequencies.[25] Risk-based interventions are not intended to supplant cost effective public health approaches such as community water fluoridation that benefit entire communities. Instead, such risk-based care would allow reallocation of current expenditures from excess care to more intense care of children at greatest risk for disease. Intensifying preventive care for at-risk children would, in turn, save significant public and private expenditures. One insurance executive stated that "Just keeping children out of the operating room gives us a big bang for the buck—probably a 45% savings for that alone."

When children lack dental coverage and access to regular dental check-ups, dental care is usually sought only when symptoms of disease become severe. Too often, this care is sought in emergency departments where treatment is costly and limited to the immediate symptoms of dental disease but not the underlying problem.

Dental Caries Intervention Should be Risk-Based

With the focus on risk-based individualized care, concepts from pediatric primary care medicine, including anticipatory guidance (counseling on preventive care topics) and chronic disease management through individualized care plans, are now beginning to find their way into dental education, financing, and dental practice. Yet, current dental financing, training, and delivery systems disproportionately support and reward traditional dental repair ("drilling and filling"). Consequently, many dental providers treat the end stage of the disease (cavities) rather than managing the disease (caries) as a bio-behavioral disease with a focus on prevention. National guidelines from pediatric primary care and dental organizations recommend that young children be assessed for early childhood caries risk no later than 1 year of age so that future preventive dental visits can be tailored to a child's risk level.[26] However, most dental providers continue to advise all patients to return for preventive visits every six months, resulting in less frequent oversight than is needed for those children at highest risk of cavities and potential excess visits for those at low risk. Lack of training in behavioral counseling, inexperience with young children, limited time, and low or no levels of reimbursement for counseling and risk-based management are some of the factors that have limited the ability of dental providers to manage dental caries as a chronic disease.[27]

Finally, opportunities to promote oral health and to intervene with children at-risk for dental caries are often missed in primary care settings (e.g., pediatrician's offices). In spite of national recommendations from pediatric and dental care provider groups on the importance of routine dental care,[28,29] a significant proportion of children do not receive any routine dental check-ups. In 2004, only 37.2% of all US children received a preventive dental service. Poor and low-income children were only about half as likely to have a dental visit as were higher income children despite their higher caries experience.[30] In a national study, advice from a health care provider on the need for routine dental check-ups was only offered for less than half of all children ages 2-17 years.[31] Primary care providers receive little training on the oral health of children even though they are an important access point for preventive care. Finally, few families are aware of the dynamics of this disease and how best to prevent it or manage its progression.[32]

In spite of the significant effects of tooth decay on children's oral health and wellbeing, much more work remains to be done if the disease burden is to be reduced."

Systems Can be Reoriented to Focus on Addressing Dental Caries as a Chronic Disease

Many leaders in the dental community now recognize the importance of promoting comprehensive public health efforts that have been shown to prevent dental caries with targeted intensive intervention efforts to those children at high risk for the disease. This overall approach – with systems of care that align resources to the most appropriate at-risk population – is becoming more common in other chronic health conditions including obesity prevention and treatment.[33] That realization coupled with over four decades of evidence-based research on "what works" in dental caries prevention and management are serving as a catalyst for efforts to consider how to realign and refocus policies, programs and investments accordingly.

In a system that addressed dental caries as a preventable and manageable chronic disease, universal, well-established public health strategies designed to promote the importance of oral health and prevent dental caries transmission would be provided to all children. Children deemed at high-risk for dental caries would receive a range of interventions including counseling and risk management to reduce further risk for dental caries progression. Finally, children at high-risk and with early or advanced disease would be provided intensive and ongoing services to treat and reverse progression of the disease. These practices would be embedded in a comprehensive system of care that includes: comprehensive public and private dental coverage, linkages with child-serving programs and systems (e.g., primary care, child care, schools, Head Start, WIC), workforce development, dental tracking and monitoring, and quality improvement efforts. New models for refocusing dental caries prevention and management efforts are beginning to be considered and used in more limited cases, as highlighted in the Early Childhood Caries Demonstration Project.

Many leaders in the dental community now recognize the importance of comprehensive oral health promotion and dental caries prevention initiatives combined with intensive intervention efforts targeted to those children at high risk for the disease.

The Early Childhood Caries Demonstration Project

DentaQuest Institute of Boston, Children's Hospital Boston (CHB), and Saint Joseph Hospital (SJH) (Providence, Rhode Island) formed a unique partnership to reduce and control cavities in young children who are at high-risk for early childhood caries (ECC). The Early Childhood Caries Demonstration Project is a redesign of the oral health care delivery system, based on the prevention and management of ECC. Its goals are to reduce new cavities in young children under age five, reduce operating room referrals, and reduce pain in young children.

CHB and SJH each operate large hospital-based dental clinics and like many programs of this kind nationwide, care for a disproportionate number of young children with ECC. These programs also confront months-long backlogs of young children awaiting extensive dental repair in the operating room. Even as they await restorative care, many young children experience pain and dysfunction that requires programs to "leapfrog" them to the head of the line. Once dental repair is provided, frequently under sedation or general anesthesia, many children experience unacceptably high rates of cavity recurrence (23–57 percent within 6–24 months). Moreover, the care provided in the operating room setting is costly: recent estimates at CHB found that the average charges per patient in 2006 were over $10,000, including charges for general anesthesia and dental treatment.

The ECDC Project is comprised of five core program components:

1. Screening and Enrollment: Dental providers working within the hospital dental clinics identify children with dental decay and past history of cavities. With parental consent, these young children are enrolled into the ECC project for ongoing intervention and follow-up.
2. Initial and Ongoing Assessment for Dental Caries Risk: Upon enrollment, dental clinicians conduct a Caries Risk Assessment to determine a child's risk for dental caries (e.g., diet, nutrition, fluoride exposure, feeding practices). Additionally, children's mouths are tested to determine oral bacteria levels. Children return for professional re-evaluation based on their risk level. Children deemed at high-risk for ECC return within one month and periodically thereafter for preventive and restorative treatment, until the dental caries is under control.
3. Parental/Caregiver Education: Families are educated on how to reduce the risk for ECC in their child through changes in diet, feeding practices (e.g., eliminating baby bottle use after 1 year) and judicious home applications of stannous fluoride.
4. Training of Pediatric Dental Residents: Since each hospital clinic is a teaching clinic, dental residents receive training to conduct caries risk assessments, provide counseling and develop risk-based strategies with the parent to manage dental caries as a chronic disease.
5. Development of Chronic Disease Management Protocols: The project is developing protocols to guide clinicians in the use of the ECC chronic disease management model.

Outcome data of the project in reducing recurrence of cavities in these young children are expected to be available in spring 2010. However, anecdotal evidence indicates that a significant proportion of patients are returning to the hospital clinics with improved outcomes.

For more information: Dr. Man Wai Ng, DDS, MPH, Dentist in Chief, Children's Hospital Boston; e-mail: manwai.ng@childrens.harvard.edu.

Preventing and Managing Childhood Tooth Decay

Needs of Young Children and Families

Intensive (high risk, early and advanced disease): Some children and families need access to intensive interventions to treat and help reverse the spread of dental caries.

Moderate (high risk, no disease): Many children and their families need access to counseling and risk management programs, dental sealant programs and other efforts to help prevent the spread of dental caries.

Universal: All children and their families need access to public health efforts that promote the importance of oral health and help prevent dental caries.

INTENSIVE

UNIVERSAL

System Support for Dental Caries Prevention and Management

Intensive (high risk, early and advanced): Provide intensive individual services and supports to children with early and advanced dental caries.

Moderate (high risk, no disease): Provide individual services and supports to children at-risk for dental caries.

Universal: Provide universal, evidence-based, quality programs and services to prevent dental caries.

Intensive (high risk, early and advanced disease) (e.g., disease management program; diagnosis, preventive and restorative treatment plan)

Moderate (high risk, no disease) (e.g., counseling and risk management, fluoride varnish, dental sealant programs)

Universal (e.g., preventive dental check-ups, community water fluoridation, school-based preventive and screening programs, public education and awareness, dental tracking and reporting)

Core Elements of a Comprehensive System of Care

- Health Promotion and Disease Prevention
- Comprehensive Public and Private Dental Coverage
- Linkages with Child Serving Programs and Systems (e.g., primary care, child care, schools, Head Start, WIC)
- Quality Improvement
- Workforce Development
- Dental Tracking and Monitoring

Source: Adapted from the Oregon Model for Supporting Young Children's Social and Emotional Development in Early Childhood Care and Education Settings.

Implications for Policy and Practice

National and state policymakers, program administrators, children's advocates, and other key groups can advance strategies to prevent and manage dental caries in children, particularly low-income and minority children. These strategies, many of which are based on decades of established science and grounded in key principles advanced by the Children's Dental Health Project, include the following.[33]

- Develop evidence-based standards, guidelines and protocols for effective clinical, behavioral and nutritional approaches to assess individual risk, and to prevent and manage dental caries as a chronic disease. For example:
  - Invest in state level infrastructure that supports evidence-based, population-based prevention strategies such as school-based dental sealant programs and community water fluoridation.
  - Build upon and adapt existing oral health guidelines such as New York's *Oral Health Care During Pregnancy and Early Childhood Practice Guidelines* .

- Strengthen the education of dental providers (e.g., dentists, dental hygienists) and primary care providers (e.g., pediatricians, family physicians, nurse practitioners) on children's oral health, particularly in the areas of prevention, disease management and parent education. For example:
  - Encourage cross-training of medical and dental providers, and develop related programming in Early Childhood Caries management.
  - Encourage integration of oral health in primary care including prenatal visits.

- Provide incentives to professionals for education on and administration of dental caries prevention and management interventions including individualized care plans such as those used for managing childhood diabetes, asthma and obesity. For example:
  - Strengthen public (e.g., Medicaid, CHIP) and private financing systems to reimburse dental and primary care providers for fluoride varnish application, dental caries management activities, and patient referrals for appropriate care.

- Develop and strengthen policies and programs that provide dental care and education to women of child-bearing age, pregnant women and new mothers. For example:
  - Integrate dental caries disease management education into programs that serve women of child-bearing age and mothers (e.g., WIC, home visiting, Healthy Start).

- Enhance national and state policies and programs to strengthen a focus on dental caries as a chronic disease. For example:
  - Conduct a statewide summit designed to educate policymakers, providers and other key stakeholders on the need for realigning systems to focus on dental caries as a chronic disease.
  - Fund community-based demonstration programs on Early Childhood Caries disease management.

- Increase investments in national and statewide public awareness and education campaigns on the importance of children's oral health, emphasizing dental caries as a transmissible but preventable disease, and providing information on how to manage the disease. For example:
  - Inventory existing public awareness campaigns to determine opportunities to integrate dental caries prevention messages.
  - Develop state public awareness campaigns to educate the general public, providers and other key stakeholders on dental caries prevention and management.

Conclusion

The complex nature of dental caries requires a comprehensive, multi-pronged public health approach designed to promote the importance of oral health and prevent dental caries transmission in all children, and to target risk-based management efforts for those children who are more susceptible to the disease. Many important and successful initiatives exist at the national and state level. However, few policymakers and providers place a primary focus on addressing dental caries as a chronic disease that is preventable and manageable.

Federal and state investments are needed to expand well-proven programs. In some cases, current investments may need to be realigned to target the most appropriate populations. Expansions in the Children's Health Insurance Program, health care reform, and the renewed national focus on preventing chronic diseases and improving the quality of health care systems present tremendous opportunities to further advance children's oral health and ultimately, ensure that all children are healthy and achieve their optimal potential.

Trend Note Highlights

Better Health at Lower Costs: Policy Options for Managing Childhood Tooth Decay

While the oral health of children had been steadily improving, significant disparities remain[34] and tooth decay is again on the rise in young children.[35] Tooth decay is not only five times more common than asthma but consequential to children's lives.[36] Children who experience chronic tooth decay and its related pain and infection are susceptible to inadequate growth and development, speech problems, poor self-esteem, lost days in school, unhealthy adult teeth, and high costs for care treatment in childhood and adulthood.[37] Low-income and minority children experience the highest rates of disease and yet have the lowest rates of dental care.

Dental caries – the disease process that causes cavities – is largely preventable, highly manageable, and chronic. It is a complex disease process involving the interplay of diet, fluoride, and genetics that results in varying individual levels of risk for cavities.[38] Most children experience little risk for dental caries and few cavities. However, an important minority of children experience high risk and extreme and consequential disease.

Given the complex nature of this disease and the fact that it is more prevalent in certain groups of children, an efficient use of current resources may be enhanced with a combination of evidence-based prevention efforts and targeted disease management strategies. That realization coupled with over four decades of evidence-based research on "what works" in dental caries prevention and management are serving as a catalyst for efforts to consider how to realign and refocus policies, programs and investments. Addressing dental caries as a chronic disease that is mostly preventable and highly manageable is central to these efforts.

Policymakers, program administrators, children's advocates, and others can advance strategies to prevent and manage dental caries in children, particularly low-income and minority children. These strategies, many of which are based on decades of established science and grounded in key principles advanced by the Children's Dental Health Project, include the following:

- Develop national evidence-based standards, guidelines and protocols for effective clinical, behavioral and nutritional approaches to assess individual risk, and to prevent and manage dental caries as a chronic disease.
- Strengthen the education of dental providers (e.g., dentists, dental hygienists) and primary care providers (e.g., pediatricians, family physicians, nurse practitioners) about children's oral health, particularly in the areas of prevention, disease management and parent education.
- Provide incentives to professionals for dental caries prevention and management interventions, including individualized care plans such as those used for managing childhood diabetes, asthma and obesity.
- Develop and strengthen policies and programs that provide dental care and education to women of child-bearing age, pregnant women and new mothers.
- Enhance national and state policies and programs to strengthen the focus on dental caries as a chronic disease.
- Increase investments in national and statewide public awareness and education campaigns on the importance of children's oral health, emphasizing that dental caries is a transmissible but preventable disease, and providing information on how to manage the disease.
- Develop state public awareness campaigns to educate the general public, providers and other key stakeholders on dental caries prevention and management.

About the Children's Dental Health Project and the National Oral Health Policy Center

Founded in 1997, Children's Dental Health Project (CDHP) is a national nonprofit organization with the vision of achieving equity in children's oral health. CDHP designs and advances research-driven policies and innovative solutions by engaging a broad base of partners committed to children and oral health, including professionals, communities, policymakers, and parents.

The National Oral Health Policy Center at Children's Dental Health Project was created in 2008 as a collaborative effort of the Association of Maternal and Child Health Programs (AMCHP), Association of State and Territorial Dental Directors (ASTDD), Medicaid/SCHIP Dental Association (MSDA), and National Academy for State Health Policy (NASHP) with funding from the federal Maternal and Child Health Bureau of the Department of Health and Human Services, Health Resources and Services Administration. The Policy Center promotes the understanding of effective policy options to address ongoing disparities in children's oral health. The three-year initiative has set out to map a course for improving family oral health by building knowledge and skills of professionals with the ability to steer systems changes.

Acknowledgements

This TrendNote was written by Karen VanLandeghem, MPH, Health Policy and Program Consultant. Children's Dental Health Project (CDHP) Chair and Founding Director, Burton Edelstein, and CDHP staff provided invaluable content, guidance and support in the development of this TrendNote.

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Feedback for Future Trend Notes Topics:

The National Oral Health Policy Center covers emergent and emerging trends in children's oral health to educate policymakers and to advance policies and practices that improve oral health for all children, including those with physical and social vulnerabilities. Possible topics of future Trend Notes include:

- Dental quality measures
- Dental care financing
- The impact of public awareness campaigns on children's oral health

To provide your feedback to this publication and submit ideas for future Trend Notes please go to: http://survey.constantcontact.com/survey/a07e2l81913g0761g00/start

For Further Information:

The Children's Dental Health Project would like to know how policymakers are using Trend Notes and hear about additional topics of interest. To help inform future Trend Notes topics and for more information about children's oral health or this Trend Note please contact: Meg Booth, Deputy Executive Director, Children's Dental Health Project, at (202) 833-8288.

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File
HB 1537

January 11, 2010

Dear Rep. Rosenwald,

I am writing to request your support of HB 1537 – Allowing primary care providers to provide preventative oral health services to children under the state Medicaid program. I am a general pediatrician practicing at Dartmouth Hitchcock-Keene and also the President of the New Hampshire Pediatric Society, a group of approximately 275 pediatricians throughout NH.

Dental caries is the most common preventable childhood disease in our country. It is more common than either asthma or hay fever, and significantly impacts the overall health of our children. Good oral health is an integral part in the overall health of children. Poor oral health affects not only physical health, but also the overall well –being, self- confidence level and ability to succeed of those affected.

As a general pediatrician, I already see these patients many times per year for not only illnesses but also for routine health maintenance. It only makes sense that the primary health care provider perform oral health screenings when the children are in the office. A gross oral health exam, oral health risk assessment, anticipatory guidance, and varnish application for the high risk kids with referral to our dental colleagues when necessary is a vital part of preventative health care services. However, one of the biggest barriers to this currently is the lack of reimbursement for these services. Due to the extra training and time involved, primary care providers must to be reimbursed for oral health services.

New Hampshire is the ONLY state in New England which does not reimburse primary care providers for oral health care. Nationally, thirty-five states ensure payment to primary health care providers for primary prevention/intervention of dental caries through their Medicaid programs. This has been shown to improve the health and lives of those children involved and also to save money for the state by preventing complicated dental procedures which become necessary as oral health problems progress.

I would be delighted to discuss this issue with you further if you have any specific questions or concerns. Thank you so much for your consideration.

Sincerely,

Patricia L Campbell

Patricia I. Campbell, DO, FACOP, FAAP
Dept. of Pediatrics
Dartmouth Hitchcock - Keene
590 Court Street
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(603) 354-6666

File HB 1537

January 12, 2010

Dear Members of the Health, Human Services, and Elderly Affairs Committee:

In reference to HB1537: Relative to an act allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

As Director of the Council for Children and Adolescents with Chronic Health Conditions I am here to support the passing of HB 1537. New Hampshire has a growing population of children who contend with chronic health conditions and tooth decay is the single most common chronic disease among these children. Children who contend with other chronic health conditions may be at higher risk of tooth infections due to a suppressed immune system.

Also, it's estimated that nearly 20 percent of children ages 24 to 60 months contend with early childhood caries (ECC), a destructive tooth decay process that frequently requires expensive and extensive intervention, and can be transmitted from adult to child. ECC can substantially affect the overall health and well being of a child. ECC can cause severe pain, swelling, and compromise a child's ability to thrive. Delayed recognition and treatment of can result in costly restorative treatment, and can affect a person's lifelong ability to speak, thrive, learn, and work.

The American Academy of Pediatrics' Bright Futures guidelines recommend that children see a physician 11 times by age the age of two. The timing and frequency of these checkups provide a perfect opportunity to assess the health of a child's mouth, as well as provide preventive dental services. For parents who have a child with a chronic health condition the balance between visits with specialists, hospitalizations, typical well child visits and dental visits can be extremely overwhelming. Many times dental issues can be overlooked when parents are faced with a diagnosis of conditions like cancer, diabetes and cardiac conditions yet the onset of dental disease to these children can be life threatening.

Therefore, the Council for Children and Adolescents supports HB1537.

Sincerely,

Denise A. Brewitt
Executive Director, CCACHC
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HB 1537

Children's Alliance
of New Hampshire

Raising our Voices for Children

Date: 12 January 2010
Bill: HB 1537, allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

Dear Chairwoman Rosenwald and Committee Members,

I am testifying today *in support of HB 1537*, allowing primary care providers to offer preventive oral health services to children under the state Medicaid program.

The Children's Alliance and its coalition, New Hampshire's Child Advocacy Network (NH CAN), supported the study commission that sponsored this bill. In fact, having primary care providers offer preventive oral health services was a 2009 NH CAN Priority for Children and enjoyed the support of the 100 members of the NH CAN.

Dental decay is the most common chronic childhood disease in America - five times more common than asthma. The good news is that dental disease is preventable. Prevention is a stronger tool for ensuring children's well-being than corrective action. In the long run it's less expensive to prevent a problem than to pay to fix it and HB 1537 emphasizes that prevention philosophy.

All the other New England states already integrate dental care and health care. The Children's Alliance is pleased to support this bill that brings New Hampshire in line with our neighbors, enabling those children living in this state --- especially rural parts of the state --- to access oral care through their medical providers.

At a time of shrinking budgets and rising health care costs, it's a smart time to be looking at the benefits of an integrated health services delivery model.

I urge your support of HB 1537, allowing primary care providers to offer preventive oral health services to children under the state Medicaid program.

Ellen Fineberg
President, Children's Alliance of New Hampshire

New Hampshire Public Health ASSOCIATION

File HB1537

January 12, 2010

Subject: HB 1537 – An act allowing primary care providers to provide preventive oral health services to children under the state Medicaid program

Dear Chairman Rosenwald and Members of the Health, Human Services and Elderly Affairs Committee:

The New Hampshire Public Health Association asks that you **support** HB 1537 which allows primary care providers to provide preventive oral health services to children under the state Medicaid program.

Good oral health is an essential part of overall health. Dental disease is associated with heart disease, stroke and diabetes.[1] Tooth decay in children can cause pain, absence from school, difficulty concentrating on learning, and poor appearance. Low income children are more likely to suffer from these problems.[2] The New Hampshire Department of Health and Human Services just released their *Third Grade Healthy Smiles –Healthy Growth Survey*. The results showed that 43.6% of New Hampshire's third graders experienced tooth decay and 12% of them had untreated tooth decay. In addition, students participating in the free and reduced lunch program experienced more tooth decay and were less likely to have dental sealants.[3]

Dental disease is preventable. The New Hampshire Public Health Association (NHPHA) supports access to preventative and therapeutic oral care for all. While there have been recent efforts to improve access to professional oral care for New Hampshire's indigent, access remains a major problem for many of the State's high risk populations such as children and the elderly. NHPHA supports initiatives for increased access to evidenced based screening and preventative care for oral health, including fluoridation and application of dental sealants.

The proposed legislation before us today will help provide low income children with better access to preventive oral health services. Individuals are more likely to see a physician rather than a dentist, and this is especially true for very young children. Trained primary care providers will not only be able to deliver services such as dental screenings and fluoride varnish treatments, they can also help assist their patients in finding a dental home. This is important because physicians can provide preventive oral health services to those that are most at risk for dental disease.

P.O. Box 2304, Concord, NH 03302-2304
Telephone: (603) 228-2983 Website: www.nhpha.org

[1] Centers for Disease Control and Prevention: "Preventing Cavities, Gum Disease, and Tooth Loss: At a Glance 2009.

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[3] New Hampshire Department of Health and Human Services: "New Hampshire 2008-09 Third Grade *Healthy Smiles – Healthy Growth Survey*".

Medicaid-enrolled children are more than twice as likely as privately insured children to access an ED for a dental emergency suggesting that barriers to general dental care may exist for these children.[4] Furthermore, recent data submitted by NH Medicaid Office of Business and Policy indicates in 2007 there were 436 children seen in NH hospital operating rooms and another 547 children in 2008.[5] NHPHA strongly supports this bill because it will help keep health care costs down and provide access to preventive oral health services to the New Hampshire children that most need it.

The New Hampshire Public Health Association bases its opinions and recommendations on scientific evidence and fact-based strategies that promote health and reduce disease and injury. The Association has more than 200 members of individuals and organizations committed to the public health and safety of all New Hampshire residents.

I am happy to address any questions you might have regarding my letter. Please feel free to contact me at anytime at (603) 545-1389. Thank you for your attention.

Sincerely,

Kristina L. Diamond
Policy Director
New Hampshire Public Health Association

[4] New Hampshire Center for Public Policy Studies: Dental Services and Workforce in New Hampshire, January 2010
[5] Commission to study preventing dental disease among new Hampshire's children: Final Report on HB 414, November 2009.

American Academy of Pediatrics

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Patricia Isabel Campbell DO, FACOP, FAAP
President
New Hampshire AAP Chapter
Dartmouth-Hitchcock Keene
590 Court St
Keene, NH 03431-1719

Dear Dr Campbell,

It was exciting to learn more about the New Hampshire AAP Chapter's activities on primary care preventive oral health services in your state. The AAP recognizes oral health as an integral part of the overall health of children, and supports efforts to expand coverage of primary care oral health intervention by pediatricians. Primary caries prevention intervention includes gross oral examination, an oral health risk assessment, anticipatory guidance to the caregiver about the caregiver's role in caries prevention, and application of fluoride varnish to the teeth of high-risk children. In addition, pediatricians can advise the caregiver about the importance of finding a dental home, where the child can be taken whenever there is a dental problem. This prevention intervention combats dental caries, a common, chronic, and preventable disease that significantly impacts the health of children.

Dental caries is 5 times more common than asthma, and 7 times more common than hay fever.[i] The prevalence of dental caries in children ages 2-4 years has actually increased in the United States from 18% of children in 1988-2004 to 24% in 1999-2004.[ii] Tooth decay particularly affects children from low-income families. A recent Government Accountability Office (GAO) report estimated that 6.5 million children aged 2-18 in Medicaid had untreated tooth decay in 2008, nearly twice the rate of tooth decay as children with private insurance.[iii] Dental caries can result in significant pain and loss of tooth structure and teeth, can lead to other systemic disease, and has a significant impact on quality of life, learning, and self-esteem. Millions of school hours per year are lost because of dental-related illness.

Unfortunately, children in Medicaid receive significantly less dental care than other children. The GAO reports that between 2004 and 2005, only 1 in 3 children enrolled in Medicaid received dental care in the prior year. As infants and young children frequently visit office-based physician practices for well-child care in the first 5 years of life, pediatricians are well positioned to initiate primary caries prevention intervention while also facilitating referral to a dental home.

Today, 35 state Medicaid programs ensure payment to primary care medical providers for primary caries prevention intervention. This coverage not only improves the health and lives of children, but also has begun to show cost savings. For example, North Carolina data show that its Into the Mouths of Babes program reduces treatment needs for children consistently receiving services – a 40% reduction in treatment related to tooth decay for children with 4 or more preventive oral health visits.[iv]

Treatment for dental care caused by caries can be very expensive. Many children who develop caries end up needing multiple restorations, and are placed under general anesthesia in an ambulatory surgery setting. Total charges for such care can be as high as $8,000-$12,000, depending on location and number of providers involved. Primary caries prevention intervention seeks to limit caries development, where more costly treatment is needed later.

Understanding the important role the AAP can play in decreasing the prevalence of early childhood caries, the AAP has a Section specifically focused on pediatric dentistry and oral health, and has also established the Oral Health Initiative (OHI) with support from the federal Maternal and Child Health Bureau. The OHI works to address children's oral health issues through the development of training materials, communication outlets on children's oral health, and educational programs. Examples of OHI activities include a free online 13-module Continuing Medical Education (CME) oral health risk training program, an oral health preceptorship program, a 2008 National Summit on children's oral health, and with funding from the American Dental Association Foundation, the Chapter Advocate Training on Oral Health (CATOOH) program. As part of this initiative, a representative from each of the 66 AAP Chapters will be trained to serve as a Chapter Oral Health Advocate (COHA). Through the OHI, the AAP will continue to support the education, training, and spread of physician knowledge of these critical services.

Again, thank you for updating the AAP on your state-level activities. The AAP supports your efforts to ensure that the oral health needs of children in New Hampshire's Medicaid program are met.

Sincerely,

/s/

Judith S. Palfrey MD, FAAP
President
American Academy of Pediatrics

JSP/dw

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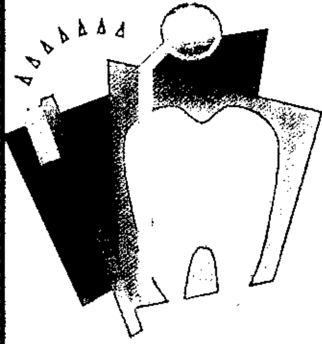
[i] U.S. Department of Health and Human Services. Oral health in America: A report of the surgeon general. Rockville, MD: National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.
[ii] Tomar S, Reeves A. Changes in the Oral Health of US Children and Adolescents and Dental Public Health Infrastructure Since the Release of the Healthy People 2010 Objectives. *Academic Pediatrics*. 2009; 9:388-395
[iii] US Government Accountability Office. Medicaid: Extent of dental disease in children has not decreased, and millions are estimated to have untreated tooth decay. Washington, DC: US Government Accountability Office; 2009.
[iv] King R. Into the Mouth of Babes: The North Carolina Experience (Webinar presentation). September 24, 2009. Available at: http://www.nashp.org/archives/1506. Accessed January 7, 2010.

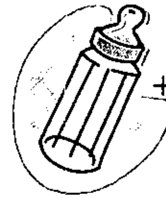


Teeth are Important
10 Simple Ways for a Healthy Smile

1. Lift the lip every month, look for early cavities-white chalky lines along the gum line

2. Clean child's teeth and gums twice daily.

3. No bottles or sippy cups in bed-unless there is water in it.

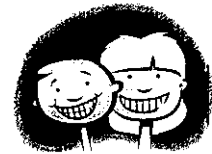


+ Water =

4. Once teeth have come in, don't let your child fall asleep while nursing or bottle feeding

5. Wean from bottle by age 1-introduce cup at 6 months

6. Don't share germs –
   do not clean pacifier in your mouth
   do not eat food off the same spoon



7. Love your children by giving teeth healthy snacks – choose water, fruit, cheese, milk.

8. Team brush until age 8-adult help at least once a day, motivate using music or stickers, very small amounts of toothpaste

9. Floss - if the teeth touch then you need to floss

10. Follow your doctor's instructions for giving daily fluoride

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these flyers please contact Malone Cloitre, Southern NH AHEC:
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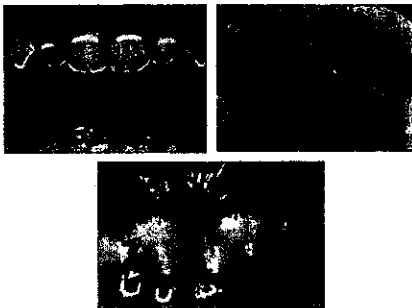
Integrating Oral Health Into Primary Care

Early Childhood
Infants - Age 5

Early Childhood Caries

WHAT TO LOOK FOR

Check for early signs of ECC: white spots



Not All Patients

Just High-Risk

Making it useful

- "Next generation" presentation
- Core messages
- Educational materials
- Utility in busy practice
- Your ideas

Core Messages

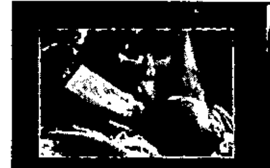
- Caries Development
- Risk Assessment
- Behavioral risks
- Lift the Lip
- Factors in Fluoride

Caries Development

- Bacterial infection
- Vertical transmission
  - Maternal colonization
  - Mother to infant transmission
- Early transmission vs. late
- Outcomes – the later the better

Bacterial Infection

- Usually transmitted from mother to child
- Any principal caregivers
- Often strong family history of decay

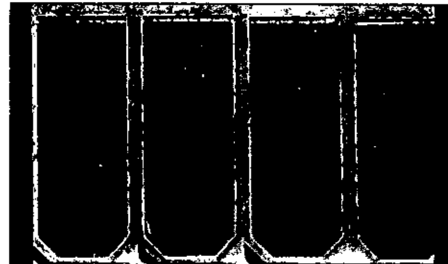


Simple Ways Bacteria is Shared

- Kissing on the mouth
- Sharing utensils
- Testing baby's food
- "Cleaning" a dropped pacifier

Streptococci mutans

$<10^5$ CFU/ml saliva $\geq 10^5$



Risk Assessment

- Family Hx of decay – maternal, siblings
- SES
- Obvious behaviors – bottle in bed, high frequency and duration breastfeeding, ad lib access to sippy cup, frequent sugar intake

AAPD Caries-Risk Assessment Tool - Questionnaire

- Decay in past 12 mos
- Suboptimal fluoride
- Frequent (3 or more) between meal exposure to sugar or food strongly associated with caries
- Low SES or Medicaid
- No usual source of dental care
- Active decay in mother

AAPD Caries-Risk Assessment Tool – Clinical Exam

- More than1 area of enamel decalcification
- Gingivitis
- Visible plaque on upper anterior teeth
- High titers of SM
- Enamel hypoplasia
- Child with special healthcare needs
- Conditions impairing saliva composition or flow

Screening for Risk

- How to administer questionnaire?
- Risk can be determined <u>before</u> provider sees patient
- Should be flagged for every preventive visit
- Assess, Look, Refer

Behavioral Risks

- Bottles and Sippee Cup
- On-demand breastfeeding
- Retained carbohydrates
- Grazing
- Poor oral hygiene

Problem Snacks

Advice to Parents

- Brush as soon as tooth comes in
- Brush for child twice a day
- Fluoride toothpaste
  - Rice grain
  - Pea

Lift the Lip

- Good view of all teeth
- Opportunity to demonstrate cleaning
- Can be included as part of physical exam

CHECK TEETH AND GUMS

- Knee-to-knee
- Examine teeth
- Adequate light
- Visible Plaque?
- Decalcification?
- Caries?

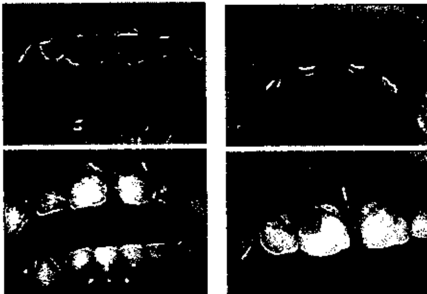
Decay and Decalcification

WHAT TO LOOK FOR

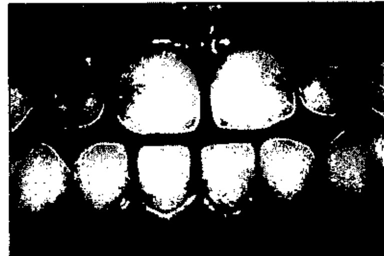
Check for early signs of ECC: white spots

WHAT TO LOOK FOR

Check for later signs of ECC: brown areas



Hypoplasia and ECC



ECC often starts on the back of upper front teeth

Check with Mirror

Fluoride Benefits

- Enamel more resistant to acids
- Promotes remineralization
- Inhibits plaque
- Concentrated in plaque and released during acid attack

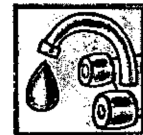
Fluoride

- Topical effect primarily
- Drops on teeth or in water
- Chew then swish the chewables
- Do not rinse after brushing
- Supplementation chart in each room

FLUORIDE SUPPLEMENTS

Fluoride

- Supplementation most important for high risk children
- Should know Fluoride concentration of water supply
  - Often a road block
  - Some bottled water is fluoridated
  - Streamline water testing



Testing the water

- Test kits: NH DES Lab 271-3445
- Have results sent to practice
- MCH patients
- CRFHC model
- Community Fl from CDC website: http://aoos.nccd.cdc.gov/mwf/index.asp
- Strategy should be more aggressive for greatest risk patients

Educational materials

- Include all materials in a packet for all ages
- Reinforce at each visit
- How does practice manage patient education materials?
  - In exam room?
  - Flag for handing out at discharge?
  - Designated clinical person to f/u, reinforce, answer questions before leaving – nurse, nutritionist, MA

Education for You

- American Academy of Pediatrics Oral Health Initiative http://www.aap.org/commpeds/dochs/oralhealth/training.cfm
- University of Minnesota, Dr. Deinard's Physician Oral Health Training http://meded1.ahc.umn.edu/fluoridevarnish/
- Univ. of Iowa ECC Prevention http://www.hhs.state.ne.us/dentsl/forum/PP/Kanellis.pdf

Credits

- State Oral Health Collaborative Systems Grant, Maternal and Child Health Bureau, Health Resources and Services Administration
- Southern NH Area Health Education Center
- New Hampshire Department of Health and Human Services, Oral Health Program
- American Academy of Pediatrics

Hope Saltmarsh, RDH, Med

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Beyond the dmft: The Human and Economic Cost of Early Childhood Caries

Paul S. Casamassimo, Sarat Thikkurissy, Burton L. Edelstein and Elyse Maiorini

J Am Dent Assoc 2009;140;650-657

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Beyond the dmft
The human and economic cost of early childhood caries

Paul S. Casamassimo, DDS, MS; Sarat Thikkurissy, DDS, MS; Burton L. Edelstein, DDS, MPH; Elyse Maiorini, BS

ABSTRACT

Background. Early childhood caries (ECC) is the most common disease of childhood and often is accompanied by serious comorbidities affecting children, their families, the community and the health care system. This report describes morbidity and mortality associated with ECC and its treatment.

Methods. The authors reviewed the literature for descriptions and quantification of morbidity associated with ECC and organized a wide range of studies into a visual model—the morbidity and mortality pyramid—that begins to convey the breadth and depth of ECC's penetration.

Results. ECC exacts a toll on children, affecting their development, school performance and behavior, and on families and society as well. In extreme cases, ECC and its treatment can lead to serious disability and even death. In finding access to care and managing chronic pain and its consequences, families experience stress and, thus, a diminished quality of life. Communities devote resources to prevention and management of the condition. The health care system is confronted with management of the extreme consequences of ECC in hospital emergency departments and operating rooms.

Conclusions. Traditional epidemiologic measures such as the decayed-missing-filled teeth (dmft) index do not adequately portray the effects of ECC on children, families, society and the health care system.

Clinical Implications. The impact of prevention and management of ECC requires the attention of health care professionals and decision makers and extends well beyond the dental office to regulatory and child advocacy agencies as well as public health officials and legislators.

Key Words. Dental caries; quality of life; pediatric dentistry; caries susceptibility.

JADA 2009;140(6):650-657.

The death of 12-year-old Deamonte Driver in 2007 as a result of untreated dental caries[1] gave lack of access to dental care a new and disturbing face for many Americans—that is, the potential for serious morbidity and even death resulting from dental caries. Behind the headlines and outrage surrounding that watershed event exists a shadow world of suffering, pain, diminished quality of life, and even death known to but a few on the front lines of the early childhood caries (ECC) epidemic. The educated, insured and employed, including many in the dental profession, have been shielded from the consequences of untreated ECC experienced by hundreds of thousands of the 4.5 million children who develop the condition annually. Death and serious morbidity resulting from ECC and its treatment are not new or confined to one disseminated infection. Death—resulting from local anesthetic overdose, sedation or general anesthesia mishap and even choking[2]—has in fact happened in attempts to treat this most common of all chronic childhood diseases. While these

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Dr. Thikkurissy is an assistant professor, Division of Pediatric Dentistry, Department of Dentistry, The Ohio State University College of Dentistry, Columbus.
Dr. Edelstein is a professor of clinical dental medicine and clinical health policy and management and the chair, Section of Social and Behavioral Sciences, College of Dental Medicine, Columbia University, New York City.
Ms. Maiorini is a research assistant, Division of Community Health, College of Dental Medicine, Columbia University, New York City.

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extreme events tend to come before the public, the daily consequences of ECC to families, the community and society often go unnoticed.

Traditional surveillance measures for ECC fall short in conveying ECC's impact and in connecting it to the full range of consequences experienced by affected children and their families. Dental epidemiologic measures such as the decayed, missing and filled surfaces (dmfs) and decayed, missing and filled teeth (dmft) indexes do not imply the full scope of the disease's impact on children, families, society and the health care system. According to Jacques,[3] "The ultimate value of any classification system ... will be determined by its ability to provide the user with information that will assist in understanding or solving clinical problems."

Similarly, utilization measures such as treatment visits fail to impart a robust picture of the effects of ECC. Service utilization is an imperfect surrogate for morbidity,[4] as the true impact of a disease often lies outside the realm of direct medical care delivery. While consequences of ECC—explored in this article—are far-ranging, supportive data often are dispersed, difficult to find or not collected at all. In this report, we review evidence from a variety of perspectives to argue that the consequences of symptomatic ECC are multiple and significant and that broader surveillance of the disease's impact is needed.

BEYOND THE BIOLOGICAL MODEL: A MORBIDITY PYRAMID

The presence of high levels of ECC, despite a reduction in permanent-dentition caries through fluoridation of water and use of fluoridated toothpastes, begs for a broader look at social and behavioral factors that correlate with this form of the disease. Fisher-Owens and colleagues[5] proposed a model for pediatric oral disease that superimposes child, family and community factors over the classic Keyes biological model to indicate the influence of these nonbiological factors on caries initiation (Figure 1). Various additional research efforts support a relationship between ECC and these behavioral, environmental and social factors.[6-10] Consistent with the "common determinants" approach to understanding disease occurrence in populations,[11] coincident morbidities are common in ECC.[12,13]

A traditional method of describing disease impact is a morbidity and mortality (M&M) pyramid, in which increasingly severe consequences are stacked one on another.[14] ECC, with its low rate of associated fatality and high rate of dysfunction, takes on the classical shape, with a broad base and narrow apex (shown in Figure 2 [page 653] as Type A).[15] A disease with a high degree of fatality, such as pancreatic cancer with its low five-year survival rate, may appear as an inverted pyramid[16] (Type C), while one with an intermediate degree of fatality appears more as a rectangle[17] (Type B). The M&M pyramid classification system provides a valuable means of quantifying disease impact through consequences ranging from mild dysfunction to death.

An M&M pyramid allows one to both observe a meaningful measure of consequence and relate that measure to other consequences. For example, for every death resulting from ECC or its treatment, one expects a certain number of hospital admissions, missed school days or episodes of pain-induced difficulty in eating or sleeping. Use of M&M pyramids can help clinicians relate the occurrence of comorbidities and, through intersecting tiers, identify groups at higher risk of experiencing illness or adverse effects.[18] The study of M&M pyramids can highlight the magnitude of a disease's effect on society and its components.[19] Through the examination of a disease's impact, health care professionals can better direct resource allocation and utilization of services to maximize prevention and treatment.[20] An M&M pyramid can represent dimensions of a disease in a range of patients, from those who are at low risk to those who experience the worst outcomes; therefore, it can provide insight into associated expenditures and loss of human capital.[21,22]

Figure 3 (page 654) depicts a draft ECC M&M pyramid. Whereas clinicians know well that the impact of ECC involves many tiers, supportive data are insufficient to fully quantify these tiers. Some must be constructed with aggregate data, often without clarity or safeguards regarding accuracy. For example, an oft-cited statistic related to dental disease is the number of days of school attendance lost,[23] but this measure includes not only the days of school that children miss because of pain or dysfunction, but also elec-

ABBREVIATION KEY. CT: Computed tomography. **dmfs:** Decayed, missing and filled surfaces. **dmft:** Decayed, missing and filled teeth. **ECC:** Early childhood caries. **ED:** Emergency department. **M&M:** Morbidity and mortality.

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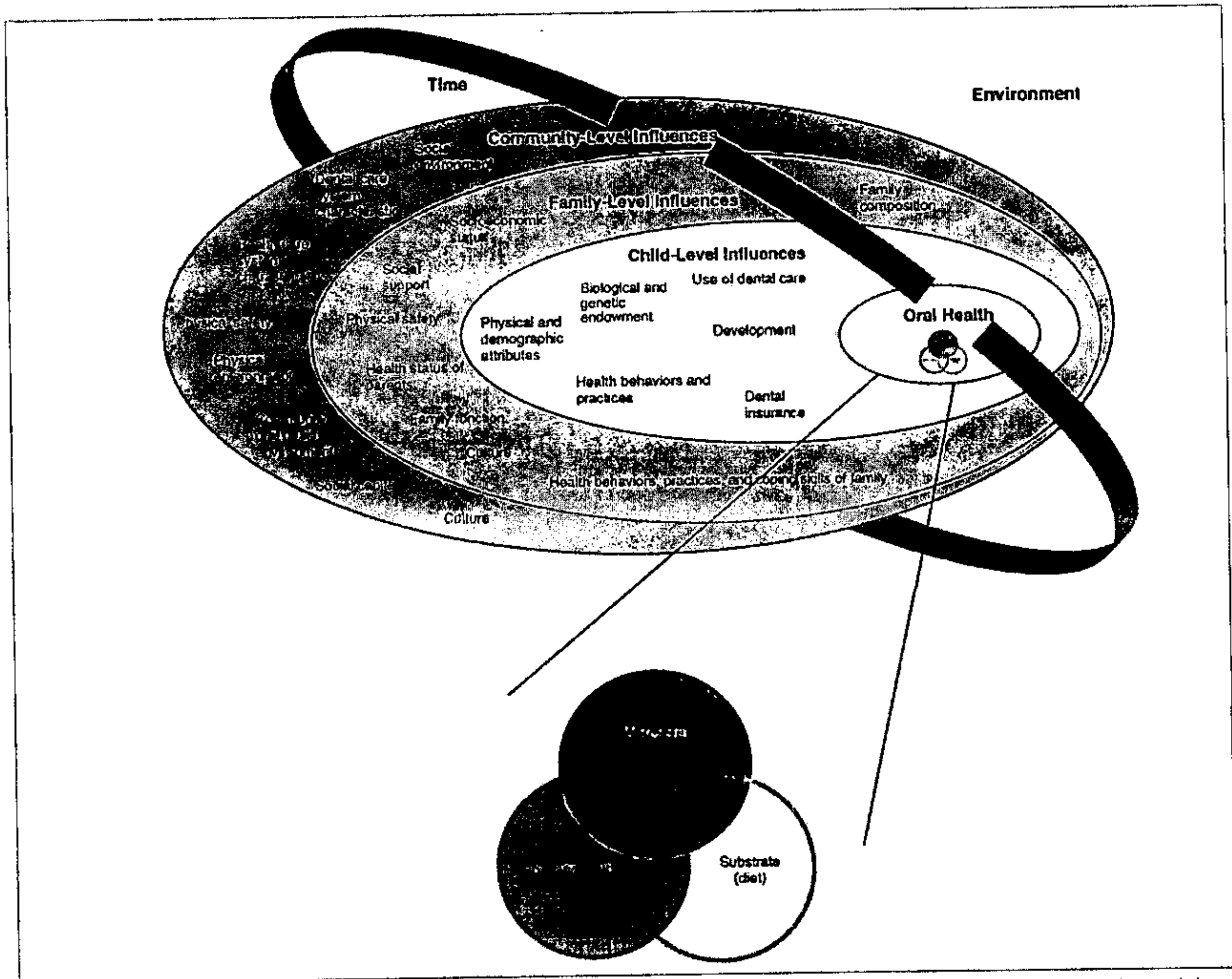

Figure 1. A multifactorial model of early childhood caries depicting possible roles for the child, the family and the community beyond the classical biological infectious disease model. Reprinted with permission of the publisher from Fisher-Owens and colleagues.[5]

tive time away from school for routine dental visits. Constructing pyramids also is hampered in part by multiple consequences. For example, there is overlap within tiers, such as the total cost of a hospitalization for a child with ECC, which might include the costs of emergency department (ED) care as well as charges for a multiday stay and for treatment in the operating room. These significant events, even if measured carefully, still may not indicate the human costs to families arising from disruption of life, work and school because of the difficulty encountered in quantifying secondary impacts.

Mortality associated with dental caries and dental intervention. The case of Deamonte Driver probably is the best-known case of caries-related mortality. Lesser known are the cases of Alexander Callender, a 6-year-old Mississippi boy who died of sepsis,[24] and Jackie Martinez, a 7-year-old California girl who choked on a crown during a dental visit.[2] Unknown to but a few involved in their care are the names of many other children who have died as a result of sedation mishaps or an overdose of local anesthetic during treatment for ECC. ECC-associated mortality secondary to infection and treatment likely never will be known owing to inadequate surveillance, lack of an ECC registry, issues of confidentiality, the terms of some legal settlements, missing or incorrect diagnoses, and even inconsistent diagnostic coding choices by hospitals and physicians. Among brain abscesses alone, 15 percent result from infections of unknown source, some or many of which may be of dental origin.[25] It is likely that mortality related to ECC and its treatment is underreported. Coté and col-

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leagues,[26] in an attempt to identify pediatric deaths related to sedation during an almost 30-year period, commented that their study sample represented a gross underreporting while also stating that dental specialists were disproportionately represented among all pediatric health providers.

Hospital admissions, ED care and use of general anesthetics. In many hospitals' EDs, a leading pediatric admission symptom is dental pain. Families seek out ED dental care for a variety of reasons, including lack of a primary care dentist, inability to pay a dentist, a perception that their child is in serious danger or pain, and proximity or convenience.[27] ED dental intervention is, in most cases, limited to management of pain and infection, leaving the source untreated at significant cost to the patient, the hospital and society and impeding a system designed and staffed for emergent medical events.[28]

Many ED admissions become prolonged hospitalizations for management of facial cellulitis. The length of stay averages five days but can be far longer, and the cost of care can be significant.[29] Ettelbrick and colleagues[30] reported in 2000 that the average cost of care across five children's hospitals for a single admission for odontogenic infection was $3,223. As with ED management of ECC infection and pain, many such hospitalizations do not result in definitive care for either the offending tooth or other carious teeth. Worse, these interventions may have untoward consequences. In a recent study of pediatric patients with facial cellulitis, researchers found that ED physicians were more likely to order computed tomographic (CT) imaging than were pediatric dentists, with no difference in treatment outcome.[31] This finding is most relevant because a growing body of literature suggests that head and neck CT imaging is responsible for an increase in thyroid cancer incidence in children.[32,33]

Treatment under general anesthesia for extensive dental repair is another costly and potentially risky consequence of ECC. Tens of thousands of young children in the United States undergo restoration and extraction of teeth under general anesthesia annually. The absolute numbers are not known as, for example, dental office–based use of anesthetics may not be recorded and dental treatment performed in conjunction with physicians' surgical services may not be tracked for either medical or dental procedures in existing registries. Estimates available

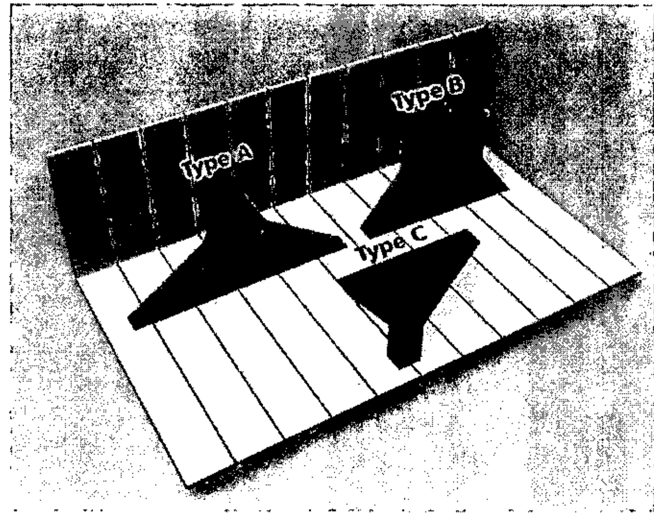

Figure 2. Examples of the morbidity and mortality pyramid, the shape of which is based on the characteristics of an individual disease entity. Reprinted with permission of the publisher from Wadman and colleagues.[15]

are based largely on records of Medicaid-insured children treated in hospitals. White and colleagues[34] reported that more than 5,500 children received general anesthetics for dental services in North Carolina alone across a two-year period. Griffin and colleagues[35] reported that more than 2,100 Medicaid-covered children received dental treatment under general anesthesia in Louisiana in a one-year period, with 60 percent of these children being 3 years or younger. The costs of these services to families and the public are significant, with mean costs in this one study calculated at $1,508 per admission.[35] Extrapolating these costs across tens of thousands of children who receive general anesthetic services annually in the United States exposes an expenditure of millions of dollars for treatment of a largely preventable disease. The human toll of treating children under general anesthesia also can be significant. Cravero and colleagues[36] included dental cases in their assessment of adverse events in sedation and general anesthesia, stating that of all patients who receive these services, the pediatric population is at highest risk and has the lowest tolerance for error.

ECC, child development and well-being. Parents of children seeking emergency dental care reported that 19 percent of the children experienced interference with play, 32 percent with school, 50 percent with sleeping and 86 percent with eating.[37] As early as 1992, Acs and colleagues[38] reported a relationship between ECC

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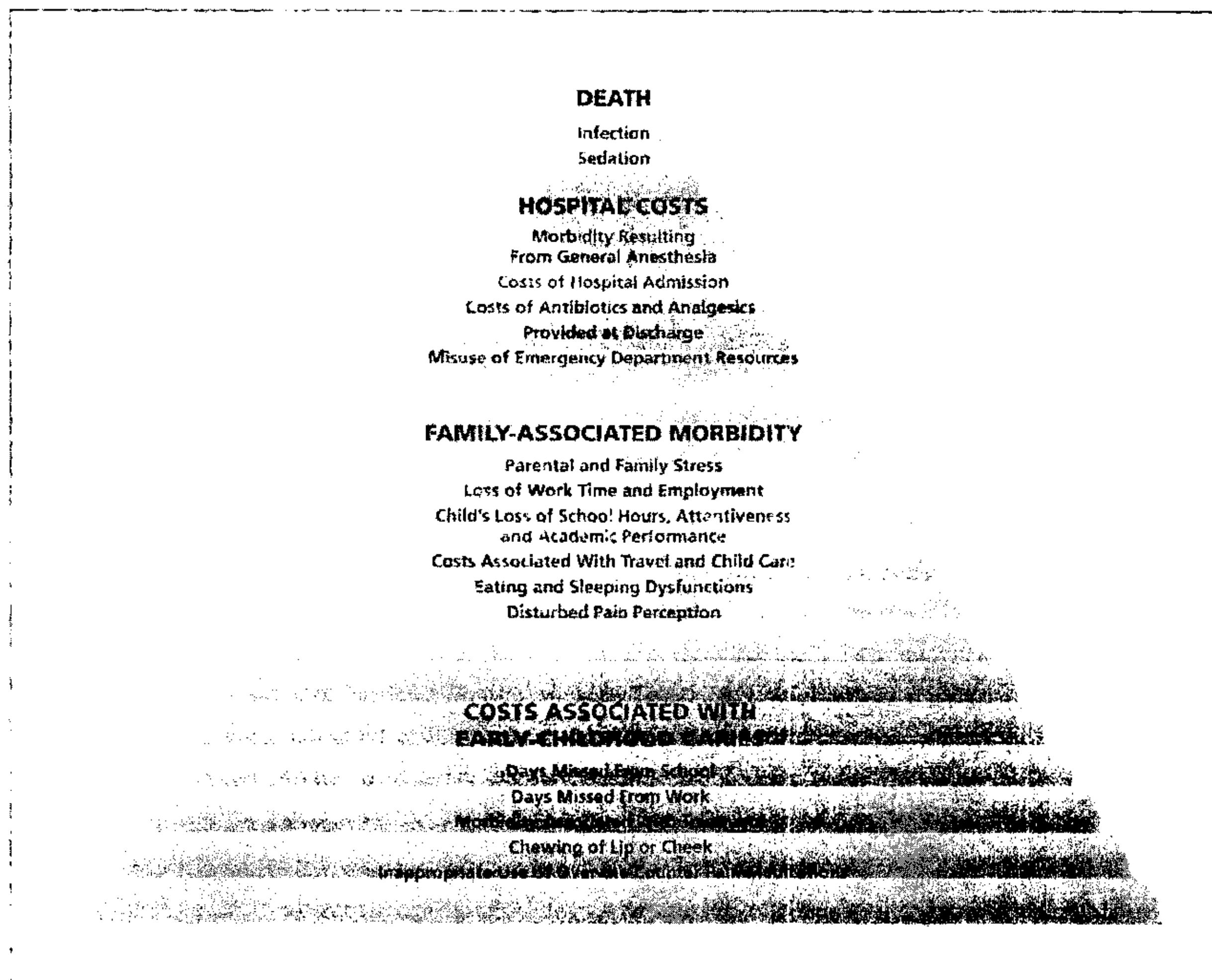

Figure 3. A proposed early childhood caries morbidity and mortality pyramid.

and failure to thrive—a condition of poor growth in young children—in a cohort of low-income children. Body measurements and blood test results indicative of malnourishment are significantly associated with severe ECC and suggest iron-deficiency anemia.[39] These reports and others stimulated interest in the effects of ECC and its treatment on child growth, looking at factors such as dysfunctions in eating, sleeping, mood and attention. Knowledge of the impact of ECC on the development of the child in physical, emotional and intellectual terms is fragmented. Episodic pain from dental caries is well-established as a constant finding, even from an early age, affecting up to 20 percent of preschoolers.[37,39-41]

The effect of ECC-related pain on distraction from learning and school performance, while not generally measured, is significant. One cross-sectional study reported that more than one in 10 schoolchildren experienced tooth pain,[42] and another identified an association between poor systemic and oral health and poor school performance.[43,44] Anecdotally, school systems nationwide, particularly those that serve a significant low-income population, report that dental problems contribute to learning difficulties. School nurses act as dental case managers on a daily basis.[45] A study in Michigan has documented loss of sleep, inability to concentrate in school and absences from school all caused by dental caries–related pain.[46]

When the federal government last surveyed the impact of caries on the activity of children in 1996, a rough estimate of 9.3 percent of U.S. children younger than 5 years experienced "restricted activity days," and an additional esti-

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mated 3.7 percent of these preschoolers incurred "bed days" because of dental problems.[47] The study noted disparities by income and race that correlate closely with disparities in disease experience among subpopulations of children in the United States.

A growing concern in pediatric emergency medical care is acetaminophen toxicity caused by excessive administration of the drug by parents for management of pain.[48] Toxic doses of the medication can accumulate rapidly, causing liver damage in small children.[49] The use of acetaminophen for management of ECC-related pain is common, but its extent and effect remain unknown.

Consequences of oral infection for systemic health have been explored more completely in adults with regard to periodontal infections than in children with regard to odontogenic infections secondary to ECC. The biological rationale for oral-systemic associations, however, may have strong utility for anticipating the effect of chronic odontogenic infections on children's overall well-being. Little has been studied about the effect of chronic pulpal infection, bacteremia and circulating inflammatory proteins on a young, healthy child's function, growth and development, healing and disturbances in development of pain perception.[50] Similarly, little is yet known about the potential ECC-driven exacerbation of chronic pediatric diseases among children affected by such conditions as asthma and diabetes. Some research supports a role for ECC in both physical and emotional health, as ECC treatment ameliorates many ECC-related dysfunctions. For example, dental treatment of teeth with ECC results in pain elimination and has been associated with improved growth velocities[51] and improved quality of life.[52-54]

The effects of ECC on family, community and health care systems. ***Family.*** At the level of family consequences, there is a troubling association between ECC and child maltreatment. Sheller and colleagues[55] concluded that a dysfunctional family or social situation can lead to a recurrence of ECC, often with emotional outbursts and the threat of or actual violence. The relationship between ECC and neglect is well-established, but only recently have child maltreatment experts included dental caries in their listing of health conditions that predispose children to maltreatment.[56,57]

Community. The impact of ECC on communities is beginning to be realized. State officials have begun to recognize that citizens are concerned about dental caries and access to care.[58,59] Care of children with ECC consumes a disproportionate share of dental expenditures because of the typical extent of disease and concomitant costs of treatment under general anesthesia in the operating room. Recently adopted policies to address ECC (such as that of the American Academy of Pediatric Dentistry's Clinical Affairs Committee[59]) will bring children into dental offices far earlier in an attempt to prevent dental caries, but they will require an increase in or diversion of workforce and health expenditures. Whereas early interventions to prevent and manage ECC have been modeled as both cost effective[60] and cost saving,[61] authors from the Centers for Disease Control and Prevention[62] reported in 2005 that under current dental system capacity constraints, widespread implementation of early intervention may crowd out existing reparative care that is being provided to children with ECC.

Health care systems. ECC's impact on health care systems may well be significant. Some have proposed significant changes in dental insurance coverage to reduce care for low-risk children and expand care for high-risk children.[63] Others propose reorganization of the dental workforce, either via creating an intermediate-level therapist capable of providing disease management, restorative care or both to affected children[64] or via expanding the engagement of medical providers.[62] Both of these approaches will affect costs associated with reconfiguring the educational infrastructure, shifting practice patterns of the existing workforce and addressing the behavioral aspects of ECC management.

ECC has a tremendous, but often invisible, impact on society and the health care system. Recognition of its pervasiveness likely will drive oral health planning for the foreseeable future.

Growing evidence gathered with epidemiologic instruments supports a diminished quality of life for families with children affected by ECC,[52-54] but the pressures families experience in a daily-life context are less clear. ECC is strongly associated with vulnerable subpopulations, including children of impoverished, minority, immigrant, migrant and homeless families whose social and economic capital is limited.[65] Loss of a job, loss of income for time spent taking a child to multiple dental appointments, the cost of transportation, taking time to find a willing dentist and financing

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care are real and significant issues for these families, exacerbated in today's chaotic economy.

The downward spiral of ECC has become an all-too-familiar cycle. Children develop ECC that advances to a painful level. Parents delay care because of finances and access-to-care problems, and the child's condition continues to worsen until it becomes so acute as to demand intervention regardless of the effect on the family's resources. Often, when these families finally gain access to care, they encounter significant delays, because the available treatment resources are far outstripped by the need and demand for them. Finally, the cycle is perpetuated as ECC predisposes children to future caries in primary and permanent teeth.[66-68]

SUMMARY

Surveillance measures such as the percentage of children affected by ECC or disease extent as measured by dmfs and dmft indexes need to be supplemented by objective measures of disease consequences ranging from dysfunction to death. Meaningful assessments of the effect of ECC on child development, learning and family function and the economic burdens it places on families, communities and the health care system are needed to describe the importance of this preventable disease adequately. Until such a comprehensive assessment—including routine diagnostic coding—is developed, the epidemic of ECC likely will continue to put the health and lives of children at risk, because few public and professional policymakers will consider ECC of sufficient importance to take meaningful action. Only when the picture of an affected child's life replaces a technical dental statistic will society act to redress the most common of childhood's illnesses. ▪

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Voting Sheets

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1537

BILL TITLE: **allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.**

DATE: February 2, 2010

LOB ROOM: 205

Amendments:

Sponsor: Rep. K. Miller OLS Document #: 2010 0232h

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.) **AMENDMENT 0232h**

Moved by Rep. K. Miller

Seconded by Rep. J. Cebrowski

Vote: 18-0 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. R. DiPentima

Seconded by Rep. J. Pilliod

Vote: 18-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 18-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Joan H. Schulze, Clerk

Rep. Joan Schulze

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 1537

BILL TITLE: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

DATE: ~~1/20/2010~~ 2/2/2010

LOB ROOM: 205

Amendments:

Sponsor: Rep. Miller — OLS Document #: 0232h

Sponsor: Rep. Celrawski — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.) 0232h

(1) Moved by Rep. Miller

Seconded by Rep. Celrawski

Vote: 18-0 (Please attach record of roll call vote.)

Motions: OTP, (OTP/A) ITL, Interim Study (Please circle one.)

(2) Moved by Rep. DePentima

Seconded by Rep. Pilliod

Vote: 18-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE:

(Vote to place on Consent Calendar must be unanimous.) ✓ Consent

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Joan H. Schulze, Clerk

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS (1)

Bill #: HB 1537 Title: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

PH Date: 1 / 12 / 2010 Exec Session Date: 2 / 2 / 2010

Motion: OTP Amendment #: 0232h

MEMBER	YEAS	NAYS
Rosenwald, Cindy, Chairman	18	
Donovan, Thomas E, V Chairman	1	
French, Barbara C	2	
Schulze, Joan H, Clerk	3	
Tilton, Joy K	4	
Butcher, Suzanne S	5	
Bridgham, Robert G	6	
Merrick, Evalyn S	7	
Russell, Trinka T	—	
DiPentima, Rich T	8	
Miller, Kate W	9	
Batula, Peter L	10	
McMahon, Charles E	—	
Pilliod, James P	11	
Emerson, Susan	12	
Case, Frank G	13	
Millham, Alida I	14	
Wells, Roger G	15	
Cebrowski, John W	16	
Kotowski, Frank R	17	
TOTAL VOTE:	18	0

Printed: 1/12/2009

OFFICE OF THE HOUSE CLERK

2009 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

(2)

Bill #: HB 1537 Title: allowing primary care providers to provide preventive oral health services to children under the state Medicaid program

PH Date: 1 / 12 / 2010 Exec Session Date: 2 / 2 / 2010

Motion: OTP/A Amendment #: 0232h

MEMBER	YEAS	NAYS
Rosenwald, Cindy, Chairman	18	
Donovan, Thomas E, V Chairman	1	
French, Barbara C	2	
Schulze, Joan H, Clerk	3	
Tilton, Joy K	4	
Butcher, Suzanne S	5	
Bridgham, Robert G	6	
Merrick, Evalyn S	7	
Russell, Trinka T	—	
DiPentima, Rich T	8	
Miller, Kate W	9	
Batula, Peter L	10	
McMahon, Charles E	—	
Pilliod, James P	11	
Emerson, Susan	12	
Case, Frank G	13	
Millham, Alida I	14	
Wells, Roger G	15	
Cebrowski, John W	16	
Kotowski, Frank R	17	
TOTAL VOTE:	18	0

Printed: 1/12/2009

OFFICE OF THE HOUSE CLERK 2009 SESSION

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

Bill #: HB 1537 Title: This bill directs the DHHS to amend the Medicaid State plan to permit primary care providers to deliver preventive oral health services to children between 0 + 3 yrs of age. The bill requires the provider to complete certain training before offering such services + makes the program contingent upon future funding.

PH Date: 1 / 12 / 2010 Exec Session Date: / / 10

Motion: Add FN to this bill 1446:A Amendment #:

MEMBER	YEAS	NAYS
Rosenwald, Cindy, Chairman	15	
Donovan, Thomas E, V Chairman	1	
French, Barbara C	2	
Schulze, Joan H, Clerk	3	
Tilton, Joy K		
Butcher, Suzanne S	4	
Bridgham, Robert G	5	
Merrick, Evalyn S		
Russell, Trinka T	6	
DiPentima, Rich T	7	
Miller, Kate W	-	
Batula, Peter L	8	
McMahon, Charles E	-	
Pilliod, James P	-	
Emerson, Susan	9	
Case, Frank G	10	
Millham, Alida I	11	
Wells, Roger G	12	
Cebrowski, John W	13	
Kotowski, Frank R	14	
TOTAL VOTE:	15	0

Printed: 1/12/2009

HOUSE COMMITTEE ON FINANCE

EXECUTIVE SESSION on HB 1537

BILL TITLE: (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

DATE: February 18, 2010

LOB ROOM: 210-211

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Harris

Seconded by Rep. Keans

Vote: 14-8 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

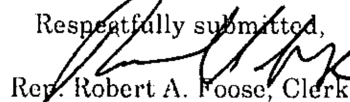
Vote: (Please attach record of roll call vote.)

(REGULAR) or CONSENT CALENDAR VOTE: (Please circle one.)

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,



Rep. Robert A. Foose, Clerk

HOUSE COMMITTEE ON FINANCE

EXECUTIVE SESSION on HB 1537

BILL TITLE: (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

DATE: February 18, 2010

LOB ROOM: 210-211

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Harris

Seconded by Rep. Kurk

Vote: 14-8 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote: (Please attach record of roll call vote.)

REGULAR or CONSENT CALENDAR VOTE: (Please circle one.)

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Robert A. Foose, Clerk

FINANCE

Bill #: 1537

Title: (New Title) allowing primary care providers to provide preventative oral health services to children 0-3 years of age under the state medicaid program

PH Date: ___/___/___

Exec Session Date: 02/18/10

Motion: OTP

Amendment #: ____

MEMBER	YEAS	NAYS
~~Smith, Marjorie K, Chairman~~ Lerandeau for	9	
Nordgren, Sharon, V Chairman	14	
~~Foster, Linda T~~ Tupper Frank	10	
Eaton, ~~Daniel~~ A Grassie Anne	11	
Baroody, Benjamin C	12	
Benn, Bernard L	1	
Leishman, Peter R	2	
DeJoie, John		
Buco, Thomas L	3	
Foose, Robert A, Clerk	4	
Mitchell, Bonnie	5	
Keans, Sandra B	6	
Casey, Kimberley S	7	
Harris, Sandra C	8	
Kurk, Neal M		1
Scamman, W. Douglas		2
Anderson, Eric		3
Emerton, Larry A	13	
Rodeschin, Beverly T		4
Wendelboe, Fran		5
Ober, Lynne M		6
Dokmo, Cynthia J		
Bergin, Peter F		
Belvin, William S		7
Elliott, Robert J		8
	14	8
TOTAL VOTE:		

Printed: 1/9/2009

Committee Report

CONSENT CALENDAR

February 10, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS to which was referred HB1537,

AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. Rich T DiPentima

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS
Bill Number:	HB1537
Title:	allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.
Date:	February 2, 2010
Consent Calendar:	YES
Recommendation:	OUGHT TO PASS WITH AMENDMENT

STATEMENT OF INTENT

This bill is a recommendation from a Study Commission created last session charged with studying preventing dental disease among New Hampshire children. This bill would require the Department of Health and Human Services to amend the state Medicaid plan to allow primary care providers to be reimbursed for providing preventive oral health services to eligible children. The bill requires that primary care providers receive approved training prior to being allowed to obtain reimbursement under this program. Currently 36 states, including all the other New England States, offer this benefit in their Medicaid program. The evidence from these states has demonstrated that this program can reduce dental decay in young children by approximately 38% . Considering that there are only 24 pediatric dentists in New Hampshire, very few young Medicaid children actually see a dentist in their first 3 years of life. However, almost every child will see a primary care medical provider 12-15 times inuring this same period. As a result, we are missing a huge opportunity to prevent dental disease in children and reduce overall costs to the state. In 2007 and 2008 combined, 983 children required treatment in hospital operating rooms under general anesthesia for removal of seriously decayed teeth. The cost to the state Medicaid program was approximately $5,312,111. Much of this cost could have been prevented with improved prevention strategies. This cost represents only the tip of the iceberg, since dental disease in children is almost 100% preventable.

Vote 18-0.

Original: House Clerk
Cc: Committee Bill File

Rep. Rich T DiPentima
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

CONSENT CALENDAR

HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS

HB1537, allowing primary care providers to provide preventive oral health services to children under the state Medicaid program. **OUGHT TO PASS WITH AMENDMENT.**

Rep. Rich T DiPentima for HEALTH, HUMAN SERVICES & ELDERLY AFFAIRS. This bill is a recommendation from a Study Commission created last session charged with studying preventing dental disease among New Hampshire children. This bill would require the Department of Health and Human Services to amend the state Medicaid plan to allow primary care providers to be reimbursed for providing preventive oral health services to eligible children. The bill requires that primary care providers receive approved training prior to being allowed to obtain reimbursement under this program. Currently 36 states, including all the other New England States, offer this benefit in their Medicaid program. The evidence from these states has demonstrated that this program can reduce dental decay in young children by approximately 38% . Considering that there are only 24 pediatric dentists in New Hampshire, very few young Medicaid children actually see a dentist in their first 3 years of life. However, almost every child will see a primary care medical provider 12-15 times inuring this same period. As a result, we are missing a huge opportunity to prevent dental disease in children and reduce overall costs to the state. In 2007 and 2008 combined, 983 children required treatment in hospital operating rooms under general anesthesia for removal of seriously decayed teeth. The cost to the state Medicaid program was approximately $5,312,111. Much of this cost could have been prevented with improved prevention strategies. This cost represents only the tip of the iceberg, since dental disease in children is almost 100% preventable.

Vote 18-0.

Original: House Clerk
Cc: Committee Bill File

HB 1537 OTP/A (0232h) 18-0 CC

This bill is a recommendation from a Study Commission created last session charged with studying preventing dental disease among New Hampshire children. This bill would require the Department of Health and Human Services to amend the state Medicaid plan to allow primary care providers to be reimbursed for providing preventive oral health services to eligible children. The bill requires that primary care providers receive approved training prior to being allowed to obtain reimbursement under this program. Currently 36 states, including all the other New England States, offer this benefit in their Medicaid program. The evidence from these states has demonstrated that this program can reduce dental decay in young children by approximately 38% . Considering that there are only 24 pediatric dentists in New Hampshire, very few young Medicaid children actually see a dentist in their first 3 years of life. However, almost every child will see a primary care medical provider 12-15 times inuring this same period. As a result, we are missing a huge opportunity to prevent dental disease in children and reduce overall costs to the state. In 2007 and 2008 combined, 983 children required treatment in hospital operating rooms under general anesthesia for removal of seriously decayed teeth. The cost to the state Medicaid program was approximately $5,312,111. Much of this cost could have been prevented with improved prevention strategies. This cost represents only the tip of the iceberg, since dental disease in children is almost 100% preventable.

cR

HB 1537, allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program, **OUGHT TO PASS WITH AMENDMENT.**

Rep. Rich T. DiPentima for Health, Human Services and Elderly Affairs: This bill is a recommendation from a Study Commission created last session charged with studying preventing dental disease among New Hampshire children. This bill would require the Department of Health and Human Services to amend the state Medicaid plan to allow primary care providers to be reimbursed for providing preventive oral health services to eligible children. The bill requires that primary care providers receive approved training prior to being allowed to obtain reimbursement under this program. Currently 36 states, including all the other New England States, offer this benefit in their Medicaid program. The evidence from these states has demonstrated that this program can reduce dental decay in young children by approximately 38% . Considering that there are only 24 pediatric dentists in New Hampshire, very few young Medicaid children actually see a dentist in their first 3 years of life. However, almost every child will see a primary care medical provider 12-15 times inuring this same period. As a result, we are missing a huge opportunity to prevent dental disease in children and reduce overall costs to the state. In 2007 and 2008 combined, 983 children required treatment in hospital operating rooms under general anesthesia for removal of seriously decayed teeth The cost to the state Medicaid program was approximately $5,312,111. Much of this cost could have been prevented with improved prevention strategies. This cost represents only the tip of the iceberg, since dental disease in children is almost 100% preventable. **Vote 18-0.**

CR

Rep. DePlerlamo

COMMITTEE REPORT

COMMITTEE: HHS + E

BILL NUMBER: HB 1537 ~~allowing primary~~

TITLE: allowing primary care providers to provide preventive oral health services

DATE: 2-2-2010 **CONSENT CALENDAR:** YES [X] NO [ ]

[ ] OUGHT TO PASS

[X] OUGHT TO PASS W/ AMENDMENT

[ ] INEXPEDIENT TO LEGISLATE

[ ] INTERIM STUDY (Available only 2nd year of biennium)

Amendment No. 0232h

STATEMENT OF INTENT:

COMMITTEE VOTE: 18-0

RESPECTFULLY SUBMITTED,

Rep. [signature]
For the Committee

- Copy to Committee Bill File
- Use Another Report for Minority Report

Rev. 02/01/07 - Yellow

REGULAR CALENDAR

COPY

February 23, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Majority of the Committee on FINANCE to which was referred HB1537,

AN ACT (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program. Having considered the same, report the same with the recommendation that the bill OUGHT TO PASS.

Rep. Sandra C Harris

FOR THE MAJORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MAJORITY
COMMITTEE REPORT

Committee:	FINANCE
Bill Number:	HB1537
Title:	(New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.
Date:	February 23, 2010
Consent Calendar:	NO
Recommendation:	OUGHT TO PASS

STATEMENT OF INTENT

HB 1537 is legislation that was recommended by a study commission established by HB 414. The commission was charged to study preventing dental disease in children. This bill directs reimbursement to appropriately trained primary care doctors/pediatricians who do oral screenings and preventative services on Medicaid eligible children age 0-3 years old. Health, human services and elderly affairs reported no opposition to the bill. Supporters included Dr. Susan Lynch and the committee vote was 18-0. The finance committee voted 14-8 for this bill which increases the network of providers to include dentists and primary care/pediatricians. Studies show that children at this age have much more contact with primary care/pediatricians than dentists. This change should greatly lessen the high costs of emergency room visits and surgeries for these children. Finance also feels that this is a very appropriate way to redirect dollars to which these children are already entitled. The majority of 14-8 saw that this bill does not increase the services to which these children are entitled but does increase the number of providers that can alleviate their pain and suffering.

Vote 14-8

Rep. Sandra C Harris
FOR THE MAJORITY

Original: House Clerk
Cc: Committee Bill File

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

FINANCE

HB1537, (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program. OUGHT TO PASS.
Rep. Sandra C Harris for the Majority of FINANCE. HB 1537 is legislation that was recommended by a study commission established by HB 414. The commission was charged to study preventing dental disease in children. This bill directs reimbursement to appropriately trained primary care doctors/pediatricians who do oral screenings and preventative services on Medicaid eligible children age 0-3 years old. Health, human services and elderly affairs reported no opposition to the bill. Supporters included Dr. Susan Lynch and the committee vote was 18-0. The finance committee voted 14-8 for this bill which increases the network of providers to include dentists and primary care/pediatricians. Studies show that children at this age have much more contact with primary care/pediatricians than dentists. This change should greatly lessen the high costs of emergency room visits and surgeries for these children. Finance also feels that this is a very appropriate way to redirect dollars to which these children are already entitled. The majority of 14-8 saw that this bill does not increase the services to which these children are entitled but does increase the number of providers that can alleviate their pain and suffering. Vote 14-8.

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

February 23, 2010

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Minority of the Committee on FINANCE to which was referred HB1537,

AN ACT (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program. Having considered the same, and being unable to agree with the Majority, report with the following recommendation that the bill be REFERRED FOR INTERIM STUDY.

Rep. Neal M Kurk

FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MINORITY
COMMITTEE REPORT

Committee:	FINANCE
Bill Number:	HB1537
Title:	(New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.
Date:	February 23, 2010
Consent Calendar:	NO
Recommendation:	REFER TO COMMITTEE FOR INTERIM STUDY

STATEMENT OF INTENT

The minority believes that the state cannot afford to expand services at this time. The minority notes that in the current biennium, the state faces a very significant deficit that caused the governor to recently request proposals from his department heads for $140 million in general fund reductions. Next biennium, the deficit will be even greater. And that's when this bill becomes effective. It is inappropriate to attempt to bind a future legislature, and it is unfair to do so when the scope of the commitment is unclear. The revised fiscal note on this bill and the financial analysis provided by the prime sponsor differed in important respects, especially in the net cost or saving. A new Medicaid initiative whose cost or saving cannot be determined is imprudent at this time and requires further study.

Rep. Neal M Kurk
FOR THE MINORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

FINANCE
HB1537, (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program. REFER TO COMMITTEE FOR INTERIM STUDY.
Rep. Neal M Kurk for the Minority of FINANCE. The minority believes that the state cannot afford to expand services at this time. The minority notes that in the current biennium, the state faces a very significant deficit that caused the governor to recently request proposals from his department heads for $140 million in general fund reductions. Next biennium, the deficit will be even greater. And that's when this bill becomes effective. It is inappropriate to attempt to bind a future legislature, and it is unfair to do so when the scope of the commitment is unclear. The revised fiscal note on this bill and the financial analysis provided by the prime sponsor differed in important respects, especially in the net cost or saving. A new Medicaid initiative whose cost or saving cannot be determined is imprudent at this time and requires further study.

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

COMMITTEE: Finance

BILL NUMBER: HB 1537

TITLE:

DATE: 2/19/2010 **CONSENT CALENDAR:** YES [ ] NO [X]

[X] OUGHT TO PASS

[ ] OUGHT TO PASS W/ AMENDMENT

[ ] INEXPEDIENT TO LEGISLATE

[ ] INTERIM STUDY (Available only 2nd year of biennium)

Amendment No. ______

STATEMENT OF INTENT:

HB 1537 is legislation that was recommended by a Study Commission established by HB 414. The Commission was charged to study preventing dental disease in children. This bill directs reimbursement to appropriately trained primary care doctors/pediatricians who do oral screenings and preventative services on medicaid eligible children age 0-3 years old. Health, Human Services, and Elderly Affairs reported no opposition to this bill. Supporters included Dr. Susan Lynch and the Committee vote was 18-0. The Finance Committee voted 14-8 for this bill which (over)

COMMITTEE VOTE: 14-8 OTP

RESPECTFULLY SUBMITTED,

- Copy to Committee Bill File
- Use Another Report for Minority Report

Rep. Sandra C. Harris
For the Committee

Rev. 02/01/07 - Yellow

Clayman, Janet

From:	Kurk, Neal
Sent:	Friday, February 19, 2010 10:05 AM
To:	Nordgren, Sharon
Cc:	Clayman, Janet
Subject:	Blurbs
Attachments:	Blurbs 2-19-10.doc

Blurbs 2-19-10.doc
(25 KB)

Hi, Sharon,

Attached are the minority blurbs on HB 1226 and HB 1537. I appreciate the extra time you allowed me. If there are questions, please call me at 529-7253.

Enjoy the break, Neal

Rep. Kurk
February 19, 2010

HB 1537 **MINORITY: REFER FOR INTERIM STUDY.**

Rep. Neal M. Kurk for the **Minority** of Finance. The minority believes that the state cannot afford to expand services at this time. The minority notes that in the current biennium, the state faces a very significant deficit that caused the governor to recently request proposals from his department heads for $140 million in general fund reductions. Next biennium, the deficit will be even greater. And that's when this bill becomes effective. It is inappropriate to attempt to bind a future legislature, and it is unfair to do so when the scope of the commitment is unclear. The revised fiscal note on this bill and the financial analysis provided by the prime sponsor differed in important respects, especially in the net cost or saving. A new Medicaid initiative whose cost or saving cannot be determined is imprudent at this time and requires further study.

New Hampshire General Court - Bill Status System

Docket of HB1537

Docket Abbreviations

Bill Title: (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Official Docket of **HB1537**:

Date	Body	Description
1/6/2010	H	Introduced and Referred to Health, Human Services and Elderly Affairs; **HJ 6**, PG.243
1/6/2010	H	Public Hearing: 1/12/2010 11:00 AM LOB 205
1/12/2010	H	Subcommittee Work Session: 1/19/2010 8:30 AM LOB 205
1/13/2010	H	==CANCELLED== Executive Session: 1/20/2010 9:30 AM LOB 205
1/19/2010	H	Subcommittee Work Session: 1/26/2010 12:45 PM LOB 205
1/20/2010	H	==CANCELLED== Executive Session: 1/26/2010 1:00 PM LOB 205
1/27/2010	H	Executive Session: 2/2/2010 10:00 PM LOB 205
2/2/2010	H	Committee Report: Ought to Pass with AM #0232h (NT) for Feb 10 CC (vote 18-0); **HC 13**, PG.528-529
2/2/2010	H	Proposed Committee Amendment #0232h (New Title); **HC 13**, PG.572-573
2/10/2010	H	Removed from Consent Calendar (Rep Vaillancourt); **HJ 16**, PG.748
2/10/2010	H	Amendment #0232h (New Title) Adopted, VV; **HJ 16**, PG.779
2/10/2010	H	Ought to Pass with Amendment #0232h (New Title): MA VV; **HJ 16**, PG.779
2/10/2010	H	Referred to Finance; **HJ 16**, PG.779
2/11/2010	H	Full Committee Work Session: 2/16/2010 10:01 AM LOB 210-211
2/11/2010	H	Executive Session: 2/18/2010 11:00 AM LOB 210-211
2/23/2010	H	Majority Committee Report: Ought to Pass for Mar 24 (Vote 14-8; RC); **HC 22**, PG.1223
2/23/2010	H	Minority Committee Report: Refer to Interim Study; **HC 22**, PG.1223
3/24/2010	H	Ought to Pass: MA DIV 206-140; **HJ 30**, PG.1501
3/24/2010	S	Introduced and Referred to Health and Human Services; **SJ 11**, Pg.264
3/31/2010	S	Hearing: April 6, 2010, Room 103, State House, 8:45 a.m.; **SC14**
4/13/2010	S	Committee Report: Ought to Pass 4/21/10; **SC16**
4/21/2010	S	Ought to Pass, MA, VV; OT3rdg; **SJ 15**, Pg.318
4/21/2010	S	Passed by Third Reading Resolution; **SJ 15**, Pg.325
5/5/2010	S	Enrolled; **SJ 17**, Pg.411
5/5/2010	H	Enrolled; **HJ 38**, PG.1914
5/24/2010	H	Signed by the Governor 05/19/2010; Effective 07/18/2010; Chapter 0076

NH House NH Senate