

June 5, 2012

The Honorable Bernard Sanders
332 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Comprehensive Dental Reform Act of 2012

Dear Senator Sanders:

On behalf of the 156,000 members of the American Dental Association (ADA), thank you for your efforts to break down the barriers that impede tens of millions of Americans from receiving regular dental care, many of whom suffer from chronic yet preventable dental diseases.

We are pleased that the “Comprehensive Dental Reform Act of 2012” implicitly recognizes that access to care is a multifaceted problem, and that no single solution will “solve” it. Many factors can profoundly affect oral health, including poverty, geography, lack of oral health education, language or cultural barriers, fear of dental care, and the belief that people who are not in pain do not need care. Poor oral health among such a broad segment of the population is especially troubling in light of the increasing body of knowledge of the interrelationships between oral health and overall health.

The ADA is committed to breaking down these barriers and there are many provisions in your bill that we enthusiastically support.

Coverage of Dental Services under the Medicaid Program

The ADA supports the provision that extends dental services coverage to adults who are deemed eligible for medical assistance under Medicaid, including mobile and portable oral health facilities that meet state standards and certification requirements. This provision offers long overdue parity of dental services with medicine. The ADA advocated for inclusion of adult dental Medicaid coverage as part of the Patient Protection and Affordable Care Act (ACA) and we support H.R. 1606 that would provide Medicaid dental coverage for the aged, blind and disabled. Currently, the states determine whether and to what extent they provide adult dental coverage. ADA policy is that adult coverage under Medicaid should not be left to the discretion of individual states but rather should be provided consistent with all other basic health care services.

The Association strongly supports increased federal funding for dental services under Medicaid and agrees that the enhanced Federal Medical Assistance Percentage (FMAP) must be tied to state requirements. Your bill calls for increasing the federal government’s contribution by 10 percentage points to help pay for the delivery and administration of dental services. In return, the states must pay providers at a rate *not less than 70* percent of the usual fees for services within the state, as well as streamline administrative procedures and provide technical assistance (e.g. to reduce missed appointments) to increase provider participation. It is important that the bill language sets the 70 percent rate as a floor and not a ceiling. In addition, the ADA recommends the

term “70 percent” be changed to “70 percentile” as a more accurate way of determining at what point 70 out of a 100 dentists would agree that the Medicaid rate is sufficient.

This is an excellent provision but more should be done to ensure the states can afford the mandate. We propose 25 percentage points increase in FMAP for dental services as long as the federal contribution does not exceed 100 percent of the total cost. In addition, financing coverage of the newly eligible adults should be addressed in a manner similar to that done under the ACA, which generally provided states 100 percent federal funding for 2014 through 2016, 95 percent federal financing in 2017, 94 percent federal financing in 2018, 93 percent federal financing in 2019, and 90 percent federal financing for 2020 and subsequent years.

While the ADA applauds the expansion to include adults and to increase federal funding for dental services in Medicaid, we do not support the definition of ‘dental services’ in this provision. The bill defines dental services as oral health services provided by a licensed oral health care provider, *as defined by the Secretary*. Currently, each state makes decisions about who can be reimbursed by the Medicaid program within its borders, and, as long as those decisions are consistent with the state’s practice act, the federal government generally accepts them. The dental services provision gives that role to the federal government. This is inconsistent with the basic tenant of Medicaid being state-controlled and usurps the state’s proper role of tailoring such decisions for the benefit of its Medicaid-eligible citizens in favor of a “one size fits all” approach. We are also concerned that this proposed definition of dental services might affect practice determinations and ultimately undermine the dentist’s role as the only oral health professional who can diagnose and develop a treatment plan.

Case Management Grant Program

This provision authorizes the awarding of 10 grants (amounts to be determined by the Secretary) to states and eligible entities for the purpose of developing case management programs to identify eligible people who are in need of dental services, provide them with information on dentists in proximity of their homes or jobs, verify their medical, dental and financial needs, provide community-level oral health education, and help coordinate transportation. The dental services would be provided by a “licensed dental provider” with no fee or charge to the patient. “Eligible entities” are 501(c) (3) organizations that provide free care to low-income individuals or Medicaid eligible individuals. Not later than January 1, 2016, the Secretary will conduct an evaluation of the program.

We believe this program is an excellent idea as long as it is conducted in a manner consistent with state licensing laws. The ADA is piloting a new dental position whose focus includes case management skills, the Community Dental Health Coordinator (CDHC). Modeled on the community health worker, which has proven extraordinarily successful on the medical side, CDHCs will function primarily as oral health educators and providers of limited, mainly preventive clinical services. In addition, they are a critical link in helping patients who need care to navigate the system, including ensuring that the patient clears the inevitable red tape that can complicate their receiving the care to which they are entitled, finding dentists, booking appointments and helping to provide critical logistical support such as securing child care, transportation and permission to miss work in order to receive treatment.

Oral Health Education of Medical Providers and Other Non-Oral Health Professionals

The section regarding the oral health education of medical providers (physicians, nurses and pharmacists) authorizes appropriations for fiscal years 2013 through 2016 to undertake oral health education programs, including oral hygiene instruction, topical application of fluoride, and oral health screenings. The Secretary is also authorized to make grants with accredited entities to educate community health workers, social workers, nutritionists, health educators, occupational therapists and psychologists on ways to promote oral health education and to provide support for behavioral modification.

The ADA supports efforts to educate the wider health care community because it enhances the oral health literacy of the American public and puts a needed emphasis on preventing oral disease. Excessive alcohol or sugar consumption can increase the risk of oral disease. Tobacco use in any form increases the risks for gum disease and oral cancer. Educating patients about these risks and how to reduce them should be incorporated into every possible patient encounter. The ADA has been a leader in health literacy, specifically in dentistry, working alongside private and public colleagues in medicine, pharmacy, nursing and public health to advance health literacy improvement. However, it is important to fund these programs in a manner that does not dilute primary care training funds for dentists.

Emergency Funding for Oral Health Services

A program will be established to award grants (fiscal years 2013 – 2016) to eligible entities to provide *comprehensive* oral health services to underserved individuals. Entities eligible for a grant are federally qualified health centers (FQHCs), a free clinic or other health center, a health center that provides services to tribal organizations, and any other health care provider or organization that the Secretary determines has a demonstrated history of serving a high number of uninsured or low-income individuals (and that expand services beyond preventive care). A portion of the grant will be allocated toward hiring oral health care specialists, such as oral surgeons, at the entities receiving the grants.

This section also directs the Secretary to establish a program to provide *technical assistance to health centers* receiving grants. The goals are to increase efficiency and minimize missed appointments, contract with offsite providers, recruit providers, and to be able to operate outside the physical facilities. Contracting with a private dental practice that will provide comprehensive oral health services is expressly mentioned.

The ADA enthusiastically supports this provision. The ADA is collaborating with the National Association of Community Health Centers (NACHC) to increase education among our respective members on the opportunities that exist for FQHCs to provide dental services, including the ability of FQHCs to contract with private dentists in the community to serve their patients. The National Network for Oral Health Access (NNOHA), the organization that represents community health center dentists, has increased its efforts to provide health centers with technical assistance through a cooperative agreement with HRSA's Bureau of Primary Health Care. Indirectly, the ADA is a major supporter of NNOHA.

Dental Clinics in Schools

This section establishes a grant program (fiscal years 2013 – 2016) for school-based dental clinics to provide comprehensive care but also to refer patients to providers in the community for any services not provided in the clinic. The ADA recognizes that school-based oral health programs can play an important role in preventing and controlling dental caries in children and adolescents and can assist in the referral of those patients to establish a dental home. We support this provision.

Emergency Room Care Coordination with Respect to Dental Care

The Secretary is directed to establish a grant program for hospitals in partnership with an FQHC or a private dental practice that enables individuals to receive dental care at an FQHC or private dental office operated by a grant recipient rather than a hospital emergency room. There is also money allocated for emergency room physicians to be educated in oral health. The Secretary is directed to report to Congress by January 1, 2016, on the best practices determined by the program. The ADA supports this provision. It is well established that comprehensive care delivered by dental professionals is much more cost effective than palliative care in an emergency room and benefits the patient by treating the disease not just the symptoms. In addition, we recommend an expansion of the “eligible entity” definition to include local public-private partnerships that work with hospital emergency rooms, community health departments, and others to refer underserved individuals (at or below 200% of the federal poverty level) to uncompensated care. An example of such a partnership is the Calhoun County Dentists’ Partnership in Michigan, which provides uncompensated dental care to individuals who are, in return, responsible for performing community service.

Research Funding

This section authorizes funding for research with respect to oral health services (fiscal years 2013 – 2016) for the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the National Institute of Dental and Craniofacial Research (NIDCR), and the Maternal and Child Health Bureau. The ADA fully supports additional funding for these research programs and has done so for many years. For example, the ADA actively supports fluoridation as part of its mission to improve the public’s health. Dentists strongly believe community water fluoridation should be a cornerstone of a broad-based comprehensive integrated strategy for the prevention of tooth decay. Fluoridation is a public health measure that saves money. A study conducted in 2006 concluded that the New York Medicaid program spent nearly \$24.00 less in treatment costs per child in predominantly fluoridated counties versus counties with little fluoridation.

Mobile Dental Services

The Secretary is authorized to award grants to rural health clinics to provide *mobile and portable* dental services at locations such as senior centers, nursing homes, assisted living facilities, schools, and licensed day care centers that serve low income children. We recommend that language be included in this section that makes it clear that mobile and portable dental services must provide comprehensive dental care. By “comprehensive dental care” we mean it must be a coordinated approach directed by a

dentist that ensures restoration or maintenance of the oral health and function of the patient, utilizing the full range of clinically proven dental care procedures, which includes examination and diagnostic, preventive and therapeutic services. The ADA believes this is necessary because there have been problems with some mobile dental programs focusing on merely providing preventive and diagnostic services, leaving the patient with untreated dental disease and no follow-up. Continuity of care is the hallmark of successful mobile dental programs.

Dental Education – Dental Residency Programs and Oral Health Professional Student Loans

A section of the bill requires individuals in dental residency programs to provide care in emergency rooms. Another section establishes an oral health professional student loan fund for dentists, dental hygienists, and dental therapists, similar to the student loan fund in place for nursing. The ADA is unclear as to how these provisions would affect the current residency and student loan programs and will seek clarification.

Cost-Benefit Analysis Report

This section requires the Secretary to submit a comprehensive cost-benefit analysis to Congress by October 1, 2015, regarding the expansion of dental coverage under Medicaid and Medicare as provided for in this Act. The ADA is concerned that the 2015 date may be too soon to yield any meaningful data. Allowing additional time to produce a report might be an opportunity to include some data on health outcomes. The Dental Quality Alliance, convened by the ADA, is developing dental quality measures that may be used to provide a more meaningful analysis.

Coverage of Dental Services under the Medicare Program

Your bill provides Medicare coverage for routine dental services. The ADA is very aware that many of our country's vulnerable elderly do not have comprehensive dental coverage. However, Congress should target whatever limited federal resources are available toward robust and adequately funded Medicaid coverage for poor adults, which would include many seniors. We believe the only realistic approach to covering needy adults is to extend that coverage a step at a time, beginning with those whose needs are greatest and who simply cannot afford to pay for care. A new dental program in Medicare would provide coverage to all beneficiaries, including wealthy recipients who have the ability to pay, thereby misdirecting scarce resources. It also reflects the political reality that even in the best of times, seeking to expand an entitlement program is very difficult. Unfortunately, even this incremental approach is a challenge, as many Members of Congress in both political parties are looking to reduce Medicare and Medicaid expenditures (not expand the programs) in response to the current economic climate and legitimate concerns about our federal deficit.

National Health Service Corps

This section authorizes National Health Service Corps (NHSC) loan repayments for individuals licensed by a state as "dental therapists." The ADA opposes this provision because making fewer loans available for dentists is a disservice to the underserved populations affected by the NHSC loan repayment program, as they usually need more comprehensive services and have multiple co-morbidities. Only dentists can diagnose,

develop treatment plans and provide complex treatment. It would be detrimental to the patients to dilute the very scarce pool of resources available for loan repayments designed to attract dentists to an underserved location or to serve underserved populations.

Department of Veterans Affairs, Department of Defense and the Federal Bureau of Prisons

The bill allows (but does not require) the Department of Veterans Affairs (VA), the Department of Defense (DOD) and the Federal Bureau of Prisons to undertake a demonstration program to train, or to employ, “alternative dental health care providers” (which includes dental therapists) to increase access to dental care services. For the Armed Forces, the bill suggests the alternative dental health care providers could improve access for military dependents, as well.

The ADA believes these provisions in so far as they allow for training or employing dental therapists are unnecessary and inappropriate. The provisions are unnecessary because based on information the ADA has received from the above named federal agencies, the agencies are meeting their mission requirements with their current delivery systems. They have also historically done what is necessary to adjust those systems to properly serve their patients, such as the use of expanded function dental assistants. It is also important to note that current law makes it virtually impossible for family members (who have access to the TRICARE Dental Program) to be treated in military facilities, so their care will not likely be affected by this provision. The provisions are inappropriate because, for example, the typical patient in the VA is a challenge to most dentists, often presenting with such co-morbidities as diabetes and obesity, and would be highly unsuitable for someone with limited training and experience such as a dental therapist.

The VA employs about 846 dentists but only 271 dental hygienists. Ideally the ratio should be much closer to one-to-one. Over the past several months, between 1,500 and 2,000 patients, or about 0.12 percent to 0.16 percent of those eligible for VA dental care are on “waiting lists.” The lack of hygienists contributes to the waiting list as some patients may be on the list while waiting for a hygiene appointment. Ironically, training dental hygienists to become dental therapists exacerbates this problem.

The Armed Forces are also doing very well in meeting the needs of their people. Patients whose needs cannot be met by the military’s own facilities can receive care in the civilian community through the Active Duty Dental Plan (ADDP). This program, administered through United Concordia, covers all of the cost of dental treatment by civilian dentists for the active duty military personnel.

- The Navy currently has 91 percent of its 1,097 dental billets filled. Dental readiness remains from 95 percent to 99 percent at dental class one and two. The bulk of this (approximately 65 percent to 70 percent) constitutes patients in dental class one (free of dental disease). Class two means there are minor treatment needs such as dental cleanings or small cavities.
- The Army shows similar numbers. It currently deploys 974 dental officers in its 1,065 available positions, or approximately 91% manned. With regard to dental readiness, the average is about 91% in dental class one and two.

- The Air Force has 1,024 dentists for its 1,088 positions. Current dental readiness (class one and two) is 93%.

Finally, all of the military services report that recruiting is exceptional and that they have more applicants than positions.

The Federal Bureau of Prisons reports that it is able to provide care by dentists in all of its facilities and sees no need for dental therapists. The Bureau also indicated that the prison population is unique due to the secondary and tertiary disease (where immediate diagnosis and treatment are required) and demanding (highly litigious) population. They indicated therapists are not the solution. In fact, they could use more dental specialists, such as Oral Surgeons and Prosthodontists and dentists with advanced hospital residencies.

Indian Health Service

The bill allows (but does not require) the Indian Health Service (IHS) to undertake a demonstration program to train, or to employ, “alternative dental health care providers” (which includes dental therapists) to increase access to dental care services. The ADA believes this provision is unnecessary because Congress has already spoken on this matter. When it reauthorized the Indian Health Care Improvement Act as part of the ACA in 2010, Congress set the terms under which there could be possible nationalization of the Community Health Aide Program (CHAP), including use of dental therapists within CHAP.

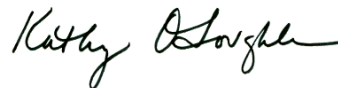
Clearly, this ambitious bill provides the degree of investment that has been needed for decades and it laudably acknowledges that oral health disparities represent a complex set of problems that call for multiple solutions. In the larger sense, the ADA believes firmly that the public health approach to ending untreated dental disease in America will require a fundamental philosophical shift from the current model of surgical intervention to one in which disease is prevented before it occurs. The nation will never drill, fill and extract its way out of what Surgeon General David Satcher, MD, famously called a “silent epidemic” of oral disease.

Again, thank you, Senator Sanders for your leadership, and we stand ready to work with you to achieve the best possible legislative outcomes in pursuing our mutual goal of a healthier, more productive nation.

Sincerely,



William R. Calnon, D.D.S.
President



Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

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