Dear Chairman Cole and Ranking Member DeLauro:

On behalf of the 158,000 members of the American Dental Association, the 9,300 members of the American Academy of Pediatric Dentistry, and the 39,000 members of the Academy of General Dentistry, we respectfully request that you continue a prohibition on the Department of Health and Human Services use of funds to train or employ alternative dental health care providers, as authorized in section 5304 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, as amended).

We request that you continue the prohibition on this funding by once again including the following bill language in the Health Workforce section of the Health Resources and Services Administration portion of the fiscal year 2016 Labor-HHS-Education Appropriations bill:

“Provided further, That no funds shall be available for section 340G-1 of the PHS Act:”

Federal funding of this provision is not necessary and would potentially take scarce resources away from proven and efficient dental education, prevention and public health infrastructure programs that are already serving the public.

The prohibition on the funds for demonstration projects for alternative dental health care providers should be maintained because:

- As authorized under the ACA, this program would cost an additional $60 million over five years in new funding or would divert those funds from programs that are proven and effective.
- To take funding for this program out of existing dental programs that support general practice, pediatric or public health dental residencies or faculty loan repayments would be counterproductive. There have been no new dental residencies funded since 2012. Dental residency positions are often critical personnel for treating people in underserved areas. Funding increases should be targeted to effective, proven efforts such as increasing dental residencies, not on new, unproven demonstration programs.
- The time for funding this section of the ACA has passed. The ACA stated that “the demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.”

Our members believe there is an untapped capacity within the current and future dental force to adequately address oral health access:

- The dentist workforce is growing. Eleven dental schools have opened since 2002. One additional school is expected to seek accreditation for admission of students in 2015. Additionally, other
universities are contemplating opening dental schools in the next few years. Many existing dental schools have substantially increased their class size.

- **Dental practices have become more efficient.** It takes only 88 dental practices in 2010 to serve the same number of dental patients as 100 practices during the first part of the 1980s.

- **“A 2013 ADA survey found that nationally 36.4% of dentists said they could take more patients.”**
- **14% of dental hygienists are not currently working as hygienists.** A majority of those hygienists could not find a position where they live, according to a 2009 survey conducted by the American Dental Hygienists’ Association.

- **In states that have increased their Medicaid dental payment rates they have significantly increased the number of dentists reaching the underserved.** After Connecticut raised its provider rates and reduced unnecessary bureaucracy, 1600 more dentists already working in the state joined the program. As a result, any child experiencing an oral health emergency is seen within 24 hours. All non-emergency appointments are scheduled within 10 days.

- **State dental associations, state hospital associations and local community health centers are working together to divert oral health patients from hospital emergency rooms (ERs).** A program in Calhoun County, “is credited with reducing the number of patients presenting to a local hospital emergency department for dental pain by 70 percent between 2006 and 2012.”

- **The existing dental workforce model is a proven delivery system.** Comprised of fully trained and licensed dentists, dental hygienists and dental assistants (expanded function dental assistants in some states); the existing dental workforce model is adaptable to virtually any situation. This model can effectively expand services to the Medicaid population with relatively minor funding increases and changes in plan administration. The Michigan Medicaid Healthy Kids Dental program, Tennessee’s TennCare, and Alabama’s Smile Alabama! are excellent examples where states used existing workforce personnel to dramatically improve access.

We understand the difficult task you face as you put together the Fiscal Year 2016 Labor-HHS-Education Appropriations bill. We greatly appreciate your consideration of this important request.

We look forward to meeting with your staff to discuss these important programs. In the meantime, if you have any questions, please contact Mary Dietrich at dietrichm@ada.org or 202-789-5178.

Sincerely,

American Dental Association

American Academy of Pediatric Dentistry

Academy of General Dentistry

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1 ADEA Dean’s Briefing Book 2014, page 8
3 Health Affairs, September 2013, Vol 32, No 9, 1646-1651