STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

ON

INSURING BRIGHT FUTURES: IMPROVING ACCESS TO DENTAL CARE AND PROVIDING A HEALTHY START FOR CHILDREN

SUBMITTED BY

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PRESIDENT

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My name is Kathleen Roth, president of the American Dental Association (ADA). I am a practicing dentist in West Bend, Wisconsin, and a Medicaid provider. I also participate in Wisconsin's State Children's Health Insurance Program (SCHIP). Chairman Pallone and members of the subcommittee, the ADA, which represents over 72 percent of the dental profession, thanks you for holding this hearing and calling attention to the need for improving access to oral health care for America's children. As you are well aware, the nation was shocked by the recent death of 12 year old Deamonte Driver—who lived only a short drive from here—from a brain infection apparently related to untreated dental disease. On behalf of the American Dental Association I extend my heartfelt condolences to the family of Deamonte. Clearly, the oral health care system failed this young man. All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us.

The impact of poor oral health can, as this tragic case shows, go far beyond the mouth. It is well documented that poor oral health can lead to oral infections that can affect systemic health, and new evidence is emerging all the time. Oral bacteria have also been associated with bacterial pneumonia in bed or chair-bound patients, and might also be passed from mother to child resulting in a higher prevalence of caries in these children. Although it's not clear if treating an oral disease will improve specific health problems, we do know that oral health is important for overall health and vice versa.

Deamonte Driver's inability to obtain timely oral health care treatment underscores the significant chronic deficiencies in our country's dental Medicaid program. Fundamental

changes to that program are long overdue, not simply to minimize the possibility of future tragedies, but to ensure that all low-income children have the same access to oral health care services enjoyed by the majority of Americans.

Disparities in Access to Oral Health Services

As U.S. Surgeon General David Satcher noted in his 2000 landmark report *Oral Health in America*, [1]dental caries (tooth decay) is the most common chronic disease of childhood – five times as common as asthma, and low-income children suffer twice as much from dental caries as children who are more affluent. According to the report, about 80 percent of the tooth decay occurs in only about 25 percent of the children – children who are overrepresented in the lower socioeconomic strata. According to the Centers for Disease Control and Prevention (CDC), [2]our society as a whole has made real progress toward reducing the morbidity of oral disease; however, existing disparities among specific populations persist. For example, children from non-Hispanic black and Mexican-American populations and families below 200 percent of poverty have a greater amount of tooth decay that non-Hispanic whites and families above the 200 percent of poverty level.

Barriers to Accessing Oral Health Care Services

There are many barriers to providing every child from a low-income family in America with good oral health care services. Some of the barriers make it difficult to supply care

[1] Department of Health and Human Services (US). Surgeon General's report on oral health, 2000. Available from: URL: http://www.surgeongeneral.gov/library/oralhealth/

[2] Beltran-Aguilar ED, Barker ZK, Canto MT, et al. Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis: United States, 1988-1994 and 1999-2002. MMWR Surveill Summ 2005;54(3):1-44.

(such as the geographic distribution of providers), some affect the demand for services (such as a caregiver's lack of appreciation of the importance of oral health), but all of them impact the ability of the underserved children to access dental services.

Supply Side Activities

On the supply side, the ADA promotes oral health through community-based initiatives, including water fluoridation, sealants and use of topical fluoride in public health programs and dental offices.

We also recognize adjustments in the dental workforce are necessary to more effectively address the special needs of underserved communities, especially children, and have endorsed the development of a new member of the dental team – the Community Dental Health Coordinator (CDHC) – to help address those needs. The CDHC will be a new mid-level allied dental provider who will enable the existing dental workforce to expand its reach deep into underserved communities and can be employed by Health Centers, the Indian Health Service, public health clinics, or private practices. CDHCs will be competent in developing and implementing community-based oral health prevention and promotion programs; providing individual preventive services (such as fluoride and sealant applications); and performing temporization on dental cavities with materials designed to stop the cavity from getting larger until a dentist can see the patient.

Congress must continue to fund crucial federal oral health care access programs. The ADA and the larger dental community have for years worked to ensure there was

adequate funding for key oral health access programs within the Department of Health and Human Services (HHS) that provide dental research and education, as well as oral health prevention and community-based access programs. Each of these programs is important as a means of helping to ensure access to oral health care, especially for the disadvantaged children in our society.

Each year, the ADA and other national dental organizations work to ensure adequate support for the Health Resources and Services Administration's Health Professions Education and Training Programs[3]; HRSA's Maternal and Child Health Bureau (MCHB)[4]; the Centers for Disease Control and Prevention's Division of Oral Health[5]; the National Institute of Dental and Craniofacial Research (NIDCR)[6]; the Ryan White HIV/AIDS Dental Reimbursement Program (Part F, Ryan White CARE Act) [7] ; and most significantly, the Title VII general, pediatric and public health dentistry residency programs

[3] Health professions education and training programs have a critical role in the recruitment and retention of minority and disadvantaged students and faculty. These programs are crucial if we are to address concerns with health disparities.

[4] Specifically, oral health projects in the Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), Title V, Special Projects of Regional and National Significance (SPRANS) account.

[5] The Centers for Disease Control and Prevention's Division of Oral Health (DOH) supports state- and community-based programs to prevent oral disease, promote oral health nationwide and foster applied research to enhance oral disease prevention in community settings. The CDC works with states to establish public health research that provides valuable health information to assess the effectiveness of programs and target populations at greatest risk. In addition, through the DOH, states can receive funds to support prevention programs that aim to prevent tooth decay in high-risk groups, particularly poor children, and reduce oral health disparities.

[6] NIDCR is the only Institute within the NIH that is committed to oral health research and training. Institute-sponsored research continues to link oral infection to such systemic diseases as diabetes, cardiovascular disease (heart attack and stroke) and adverse pregnancy outcomes (preterm birth and low birth weight). The Institute remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research.

[7] The Ryan White HIV/AIDS Dental Reimbursement Program increases access to oral health services for people living with HIV/AIDS; ensures that dental and dental hygiene students and dental residents receive the most current training; and assist in defraying the rising non-reimbursed costs associated with providing such care by dental education institutions.

within HRSA.[8] We call upon Congress to properly support these vital programs as part of our collective effort to fix the access problems for children from low-income families and other underserved.

The ADA is also very pleased that the House companion bill to S. 739, the "Children's Dental Health Improvement Act 2007," that will be cosponsored by Representatives Dingell and Simpson, will soon be introduced. That legislation will do a great deal to improve delivery of dental care in Medicaid and SCHIP and ensure a chief dental officer presence in key federal agencies, among many other initiatives.

The ADA has long supported incentives at the federal level to encourage private sector dentists to establish practices in underserved areas, such as a tax credit to establish an office in an underserved area. We also work with and support our colleagues who practice in Health Centers, which are provided section 330 funding in exchange for providing care to all regardless of ability to pay. We have an excellent working relationship with the National Association of Community Health Centers (NACHC) and encourage our private sector members to work cooperatively with the centers in their communities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers, thereby providing the centers with another option to efficiently provide dental services to Health Center patients when and where those services are needed. In addition, the ADA was the founding member of the Friends

[8] Title VII dental residency programs are instrumental in training dentists who work in underserved communities and treat Medicaid, SCHIP or other underserved populations, particularly those with special needs.

of the Indian Health Service and has for many years actively lobbied to increase funding for the IHS's dental program, including full funding for IHS loan repayments.

And dentists understand their ethical and professional responsibilities too. In the absence of effective public health financing programs, many state dental societies joined with other community partners to sponsor voluntary programs to deliver free or discounted oral health care to underserved children. According to the *ADA's 2000 Survey of Current Issues in Dentistry*, 74.3 percent of private practice dentists provided services free of charge or at a reduced rate to one or more groups (e.g., homebound, handicapped, low income). A total national estimate of the value of this care was $1.25 billion, or $8,234 per dentist. In 2003, the ADA launched an annual, national program called "Give Kids A Smile" (GKAS). The program reaches out to underserved communities, providing a day of free oral health care services. GKAS helps educate the public and state and local policymakers about the importance of oral health care while providing needed and overdue care to large numbers of underserved children. The ADA's fifth annual Give Kids A Smile event on Feb. 2, 2007, was again highly successful. More than 53,900 dental team members registered to participate on ADA.org, including 14,220 dentists. Nationwide, 2,234 programs were held. Registered participants treated some 755,600 children, and valued the care at $72,276,000 ($95 on average per child). Of course, poor children shouldn't have to depend on charity for basic dental care. These efforts are important but are no substitute for fixing the Medicaid program.

<u>Demand Side Activities</u>

University researchers seeking to identify the barriers to oral health care faced by low-income caregivers concluded that efforts need to be made to educate caregivers about the importance of oral health for overall health. [9] The ADA and other professional dental organizations agree that early intervention is very important in assuring that a child has good oral health. Accordingly, the ADA recommends that children see a dentist for the first time within 6 months of the appearance of the first tooth and no later than the child's first birthday.[10] The American Academy of Pediatric Dentistry also recommends that all children should visit a dentist in their first year of life and every 6 months thereafter, or as indicated by the individual child's risk status or susceptibility to disease.[11] The ADA also has a number of initiatives it is undertaking to address oral health literacy issues. They include: implementing an advocacy strategy to increase the number of school districts requiring oral health education for K-12 students; encouraging the development of oral health literacy continuing education programs to train dentists and allied dental team members to communicate effectively with patients with limited literacy skills; and developing guidelines for the creation of educational products to meet the needs of patients with limited literacy skills, including the involvement of targeted audiences in materials development.

Challenges Associated with the Medicaid Program

[9] S.E. Kelly; C.J. Binkley; W.P. Neace; B.S. Gale, "Barriers to Care-Seeking for Children's Oral Health Among Low-Income Caregivers," *American Journal of Public Health*, Aug 2005; 95, 8; Alumni – Research Library, pg. 1345.
[10] American Dental Association, ADA statement on early childhood caries, 2000. Available from: www.ada.org/prof/resources/positions/statements/caries.asp.
[11] American Academy of Pediatric Dentistry, Guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Available from: www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf.

To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid. Over 90 percent of all practicing dentists are in the private sector (totaling over 162,000). Safety net facilities that target underserved populations are, of course, very important but they employ relatively few dentists. Efforts to expand care *only* through safety net facilities will not fix the access problem. For example, in fiscal year 2005, Health Centers receiving section 330 funding employed about 1,738 (FTE) dentists.[12] Even after significant growth in Health Centers in the past several years, that is still less than one percent of the total of 177,686 active dentists in the United States in 2005.[13]

Seventy-five percent of Medicaid enrollees are children and their parents and about half of the program's 60 million 2006 enrollees are poor children, making it the federal government's largest health care program in terms of enrollment. [14] At the same time, according to the Congressional Budget Office (CBO), many eligible people do not enroll in the program and there have been estimates that about 33 percent of the 10 million children identified as uninsured are eligible for Medicaid. [15] So, experts estimate that over 30 million American children meet Medicaid eligibility requirements.

There are a number of factors that work against bringing more private sector dentists into the Medicaid program – but they can be overcome if we all work together. As CBO

[12] DHHS, HRSA, BPHC, 2005 Uniform Data System.
[13] American Dental Association, Survey Center.
[14] Congressional Budget Office, Medicaid Spending Growth and Options for Controlling Costs, Statement before the Special Committee on Aging, July 13, 2006, pp. 1-3.
[15] T.M. Selden, J.L. Hudson, and J.S. Ban thin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, vol. 23, no. 5 (September-October 2004), pp. 39-50.

points out, analyses of Medicaid's reimbursement rates have found them to be lower than Medicare or private insurance rates.[16] This was also discussed in a General Accounting Office study, which also recognized a number of administrative barriers. [17] In short, the vast majority of the dental Medicaid programs in the United States are woefully under funded and the reimbursement rates simply cannot attract enough dentists. Where these programs have been enhanced, the evidence is clear that dentist participation increases. In addition, high student debt pressures young dentists to go into the private sector and makes it fiscally less feasible to take public health or clinic positions. Significantly, the American Dental Education Association reported that indebtedness for dental school graduates averaged $118,720 in 2003, with public school graduates averaging $105,350 and private/State-related school graduates averaging $152,525. This level of debt puts a great deal of pressure on young dentists to set up private practices in relatively affluent areas to the exclusion of underserved areas.

Potential Solutions

In 2001, the Urban Institute wrote an early assessment of the State Children's Health Insurance Program (SCHIP) [18]and concluded that "….different delivery systems supported by competitive payments appears to be contributing to improved provider participation and better access to dental care in some state SCHIP programs." [19] Most important, the study noted what it called a "spillover" effect on the Medicaid programs in

[16] CBO, Ibid. at p. 4.
[17] General Accounting Office, "Oral Health … Factors Contributing to Low Use of Dental Services by Low-Income Populations," September 2000. p.4.
[18] The Urban Institute, "Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Inititiatives," July 2001.
[19] Ibid, p. ix.

two states – Alabama and Michigan. [20] The authors stated that the Alabama and Michigan officials reported that the early success of their dental SCHIP programs had expedited reform of their dental Medicaid programs and that data suggested that improvements in access may be occurring under Medicaid programs that are paying dentists at market rates. [21]

In October 2004, the ADA identified five state and community models for improving access to dental care of the underserved.[22] The Michigan and Alabama programs mentioned above are included among them, with Tennessee's TennCare program the other state level Medicaid model program cited. The report also identifies two community level initiatives that show great promise of enhancing access to Medicaid eligible children. The Association chose these five based on suggestions from state policymakers and other public and private sector stakeholders.

A very recent study of the first five years of Michigan's "Healthy Kids Dental" Medicaid program[23] concludes that an increasing proportion of children received dental care each year from local providers close to home; the number of dentists continues to increase; and many of the children in the program appear to have a dental home and are entering regular recall patterns. Meanwhile, the Michigan Department of Community Health expanded the program to 59 of Michigan's 83 counties, effective May 1, 2006.[24]

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[20] Ibid.
[21] Ibid.
[22] American Dental Association, "State and Community Models for Improving Access to Dental Care for the Underserved," Executive Summary, October 2004.
[23] S.A. Eklund, "Michigan's Medicaid "Healthy Kids Dental" Program: Assessment of the First Five Years," University of Michigan School of Public Health.
[24] Ibid.

Concerning the TennCare dental program, between October 2002 and October 2006, the number of dentists participating statewide grew by 112 percent and in rural counties by 118 percent.[25] This growth occurred after the dental program was "carved out" of the Medicaid medical program in 2002, whereby the dental care was administered by its own benefits manager and had its own funding stream, comprising 2 percent of the entire TennCare budget. The carve out facilitated the development of a good working relationship with the Tennessee Dental Association and other stakeholders, resulting in a streamlined dental administrative process, among other improvements. Four other states use a similar dental carve out system – California, Illinois, Massachusetts (in progress), and Virginia. Finally, the Alabama program (Smile Alabama!) has also significantly improved dentist participation. State officials note the increase in reimbursement rates and its outreach to dentists as significant contributing factors in growing that program. [26]

To be clear, the Association is not suggesting that the programs identified in ADA's state and community models document are the only ways to begin to address the oral health access problems facing low-income children – or even the best ways in all cases. We are simply suggesting that while the problems are considerable, they are not insurmountable if all parties work together. We believe there is a great deal that Congress can do to encourage other states to take similar measures to improve their dental Medicaid programs through grants and other means.

[25] J. Gillcrist, "TennCare Dental Program: Before and After the Carve Out"
[26] Smile Alabama! "Alabama Medicaid's Dental Outreach Initiative."

Conclusion

All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us. Fundamental changes to the Medicaid program are long overdue to ensure that low-income children have the same access to oral health care services enjoyed by the majority of Americans. While we have made progress toward reducing the morbidity of oral disease, significant and persistent disparities continue to adversely affect underserved populations.

Dentists understand their ethical and professional responsibilities and have tried to address the access dilemma in a variety of ways. The ADA promotes oral health through community-based initiatives, such as water fluoridation, sealants and use of topical fluoride in public health programs and dental offices. We endorse adjustments in the dental workforce, including the development of Community Dental Health Coordinators, who could greatly enhanced the productivity of our dental teams in the future and will bring the expertise needed to efficiently address the oral health care needs of many in underserved populations, especially children in low-income families. For many years, the Association has lobbied Congress to adequately fund oral health care access programs, such as the Health Resources and Services Administration's Health Professions Education and Training Programs, which is crucial in addressing concerns with health disparities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers and many state dental societies cosponsor voluntary programs to deliver free or discounted oral health care to underserved children. Of course, all of the above efforts are no substitute for fixing the Medicaid program.

To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid. Over 90 percent of practitioners are in the private sector, and with over 30 million children estimated to be Medicaid eligible, there is simply no other way to adequately serve such a large segment of our nation. We have cited examples of several states that have made great strides in fixing their Medicaid programs, such as the “Healthy Kids Dental” in Michigan, “TennCare” in Tennessee and “Smile Alabama!” in Alabama. There are certainly many more examples, especially at the community level, that have also been effective. We believe there is a great deal that Congress can do to encourage other states to take similar measures to improve their dental Medicaid programs through grants and other means.

The problems are numerous and complex, but they are not insurmountable if we have the will to take the necessary steps to fix this problem. For too long, dental disease has been the "silent epidemic." The tragic fate of young Deamonte Driver—and the many others who have died from untreated dental disease—show the gravity of untreated dental disease.

Mr. Chairman, our nation's most vulnerable citizens deserve better care than we have provided. The ADA stands ready to do its part, and we call upon our many friends in Congress to work with us to ensure that every child can face his or her future with a smile.