October 21, 2005

The Honorable Donald Sundquist, Chairman
The Honorable Angus King, Vice Chairman
Medicaid Commission
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Chairman Sundquist and Vice Chairman King:

The American Dental Education Association (ADEA) and the American Association of Dental Research (AADR) are pleased to offer recommendations regarding oral health care to the Medicaid Commission as it deliberates long-term improvements in the Medicaid program. As the major national voices for dental education and research, ADEA and AADR encourage the Commission to pursue its charge with the realization that oral health is essential to the general health and well-being of Medicaid-eligible children and adults.

Academic Dental and Research Community

The ADEA represents academic dental institutions, educators, researchers, residents and students training in these institutions. The AADR represents the oral health research community by advancing research and increasing knowledge for the improvement of oral health. Together our organizations constitute the entirety of members and institutions that are dedicated to the advancement of research, education, and the delivery of oral health care for the improvement of the health of the public.

Dental Coverage under Medicaid

All 25 million children in Medicaid under age 21 are eligible for needed dental care through the Early Periodic Screening, Diagnosis and Treatment program (EPSDT). Dental services were among the first three preventive health care services included in EPSDT. Although all children enrolled in Medicaid qualify for EPSDT services, less than one in four children on Medicaid receive them. A 2000 survey of state Medicaid program administrators found that 96 percent of respondents reported an access problem for lower-income children in need of dental care[1]. Poor children have twice the incidence of tooth decay as their non-poor counterparts. The problem is worse for children of ethnic and racial minority groups. Despite this fact, Medicaid spending for early and periodic screening is 0.4 percent of total Medicaid spending[2].

[1] "Dental Care for Medicaid Enrolled Children," Erin Nagy, July 2000, American Public Human Services Association Survey on Access to Dental Care.
[2] "2004 CMS Statistics," Table 32, Medicaid/Type of Service, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

State Medicaid programs are required to ensure that dental services are available and accessible and to provide services if a problem is identified that requires treatment. States must also inform Medicaid-eligible persons about the availability of EPSDT services and assist them in accessing and utilizing these services. Services include regular screenings and dental referrals for every child at regular intervals meeting reasonable standards of dental practice established by states in consultation with the dental profession. States must provide, at a minimum, services that relieve pain and infection, restore teeth, and maintain dental health.

Dental care for adults under Medicaid is optional. As a result, many states often reduce or eliminate funding for adult dental programs during difficult economic times. A newly released report from the Kaiser Commission on Medicaid and the Uninsured[3] examines the impact of adult dental service reductions on Medicaid beneficiaries in Massachusetts after the state cut coverage for preventive dental services (e.g., cleanings and periodic exams, periodontal treatment for gum disease and restorative treatments and crowns) to adults. While tooth extractions were still covered, dentures to replace missing teeth were not. By 2004, the number of adults receiving dental services paid for by the state program had dropped from 168,000 to 68,000. After deducting Federal matching funds from the equation, these dental cuts saved the state roughly about $16.5 million, less than one percent of the state's total share of Medicaid spending. Furthermore, between 2002 and 2003, uncompensated care reimbursements for dental services to free-standing Community Health Centers in the state increased by 54 percent.

Today, most states have caps or limits on spending for adult oral health and dental services. Forty-one states offer *only emergency care*. As states begin to recover from the recent economic recession, some are reinstating *limited* oral health and dental services for adults; however, only a relatively few states provide *comprehensive* adult services. For many Medicaid-eligible adults this is the only insurance coverage they have for oral health and dental care. Medicaid covered 66 percent of the dental expenses incurred for all people with public insurance.

Role of Academic Dental Institutions

U.S. academic dental institutions (ADIs) have access to state-of-the-art dental research and an impressive history of serving vulnerable populations. As a result ADIs have developed many innovative ways to deliver dental care to underserved populations. These institutions are most often major dental safety-net providers in states with dental schools. Through their research programs they discover state-of-the-science evidence on the growth and development of oral, dental, and craniofacial diseases and conditions that leads to advancements in technologies and improved efficiencies in the delivery of oral health care.

ADEA-AADR Recommendations

The strong record of our member institutions as major dental safety-net providers, combined with the broad range of oral health policy expertise and interests we represent, uniquely qualify our organizations to offer the following recommendations with regard to topics the Commission will be evaluating for improving the Medicaid program.

[3] "Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience, Carol Pryor, MPH, EdM and Michael Monopoli, DMD, MPH, MS, September 2005.

A. Eligibility

1. **Preserve eligibility to a basic package of dental services under the EPSDT program for children eligible for Medicaid up to 200 percent of poverty.** These children experience higher rates of tooth decay and are less likely to receive treatment. Any plan to substitute the eligibility standards of the State Children's Health Insurance Program (SCHIP) or other block grant programs for EPSDT would potentially eliminate critical dental services for millions of children. These alternatives to EPSDT would ***not*** reduce states' health care costs. Rather, they would significantly drive up costs by replacing the cost-effective preventive care provided by EPSDT with more costly emergency treatment.

2. **Require a basic dental benefit for aged, blind and disabled individuals.** The benefit should be similar to that available to children through EPSDT and provide screenings at regular intervals and medically necessary treatment as appropriate when an oral health condition is diagnosed. It would ensure that the aged, blind or disabled - who too often fall through the safety net - have access to critical oral health services. Such a benefit would help reduce widespread infection, problems with dentures, and poor oral hygiene that occur in nearly 70 percent of the nation's elderly nursing home population[4]. Almost two-thirds of community-based residential facilities report having inadequate access to dental care.[5]

B. Benefit Design

3. **Prohibit states from imposing cost-sharing or annual limits on EPSDT oral health services to children and aged, blind and disabled individuals**. Beneficiaries with incomes below $16,090 for a family of three saw their out-of-pocket medical expenses grow an average of 9.4 percent between 1997 and 2002. For these families their medical expenses grew twice as fast as their incomes (4.6 percent). For poor disabled beneficiaries the problem was worse, consuming 5.6 percent of their incomes. Furthermore, an analysis of 13 studies conducted in seven states show that cost-sharing reduces utilization[6]. Medicaid should encourage beneficiaries to seek preventive and routine dental services that can save overall health care dollars and thereby eliminate the need for more expensive care in emergency rooms. Children who receive preventive dental services early in life have costs that are approximately 50 percent lower than those of children whose dental care is neglected over time.

4. **Require state Medicaid agencies to update and develop EPSDT periodicity schedules *for dental services* to children in Medicaid in consultation with recognized dental organizations** involved in providing dental services to children. Few state Medicaid agencies have published or made separate schedules available for dental services, even though several model schedules exist for EPSDT well-child dental visits (e.g., those included in the clinical guidelines prepared by the American Academy of Pediatric Dentistry and the National Center for Education in Maternal and Child Health).

5. **Ensure adequate reimbursements for dental services.** Medicaid beneficiaries should have the same level of access to dental care that is available for other health care services in Medicaid. The program is the major source of oral health care for vulnerable and low-

[4] "The Disparity Cavity: Filling America's Oral Health Gap, Oral Health America, May 2000.
[5] "A Quarter Century of Changes in Oral Health in the United States," White BA, Caplan DJ, Weintraub JA. Journal of Dental Education 59:19-60, 1995.
[6] "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Artiga S, O'Malley M, Kaiser Commission on Medicaid and the Uninsured, May 2005.

income populations. Unfortunately, enrollment in Medicaid does not ensure receipt of oral health care services. In 2002[7], total combined state and Federal spending on Medicaid dental services was $2.7 billion or 1.1 percent of total Medicaid spending. In comparison, Medicaid spent $8.9 billion for physician services or 3.6 percent of all Medicaid spending in 2002.[8] Visits to dentists take longer than standard doctors' visits. Likewise, they require sophisticated technology, costly equipment and materials. Medicaid and other public health programs rarely take these differences into account when establishing reimbursement rates.

6. **Adjust payments to dental providers that take into account those who provide care to a disproportionate number of Medicaid patients, particularly those with complex medical and other special needs.** Few states recognize the differences in the economies of dental practice and the impact that payment decisions have on provider incentives to provide significant amounts of dental care to Medicaid beneficiaries. Reimbursement for oral health and dental care should reflect these differences as well as the additional burden of disease and complexity of treatment for Medicaid beneficiaries, especially those with cognitive and physical disabilities that have special health care needs.

7. **Develop models of care that allow primary care providers to gather data, assess, triage and refer patients to appropriate dental professionals for diagnosis and treatment.** States should be encouraged to adopt models of care that develop stronger linkages between pediatricians, family physicians, geriatricians and other primary care providers as team members with dentists in assessing oral health status. Dental schools and oral health professionals would serve as team leaders providing the necessary education and training that would enable all primary health care professionals to assess the oral health status of their patients and make appropriate referrals to dentists and allied dental professionals. Such programs would enhance the oral health knowledge base of all health professionals and allow patients to access oral health treatment at an earlier stage in the delivery system. This would permit more cost-effective treatment of Medicaid beneficiaries before their dental disease manifests in a medical emergency requiring more expensive and costly treatment.

8. **Develop innovative programs that increase access to oral health care, including collaborative partnerships between state Medicaid programs and academic dental institutions.** In some states, the Medicaid program has been an innovative laboratory for dental programs and policies that increase access to dental care for low-income and vulnerable populations. These opportunities would be enhanced by providing additional funding through demonstration projects and other programs to foster innovative programs in states that expand access to services and improve dental care for Medicaid beneficiaries. Dental schools offer several advantages that fill gaps in state Medicaid oral health programs including: 1) access to research on oral disease and prevention; 2) model programs in educating the public regarding good oral health; and 3) experience in providing oral health services to Medicaid populations including those with special needs. (See attachment entitled "Academic Dental Institutions as Safety-net Providers" for highlights of some dental school activities in Medicaid.)

[7] "Dental Services: Use, Expenses and Sources of Payment, 1996-2000," Medical Expenditure Panel Survey, Agency for Health Research and Quality, U.S. Department of Health and Human Services.

[8] ADEA figures based on data from the "2004 CMS Statistics," Table 32, Medicaid/Type of Service, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

C. Quality of Care and Outcomes

9. **Utilize Practice-Based Research Networks** (PBRNs) such as those underway at the National Institute of Dental and Craniofacial Research (NIDCR) to identify and develop the evidence base for practice guidelines in oral health. In March 2005, NIDCR awarded three seven-year grants, totaling $75 million, to establish practice-based research networks that investigate with greater scientific rigor the everyday issues surrounding the delivery of oral health care. The purpose of the PBRNs is to develop the research data to guide treatment decisions in the dentist's office. Each regional network will conduct approximately 15 to 20 short-term clinical studies over the next seven years, comparing the benefits of different dental procedures, dental materials, and prevention strategies under a range of patient and clinical conditions. The networks also will perform anonymous chart reviews, as allowed by the Health Insurance Portability and Accountability Act (HIPAA), to generate data on disease, treatment trends, and the prevalence of less common oral conditions.

10. **Conduct Dental Health Services Research.** More analysis of oral health data for Medicaid is needed from the Agency for Healthcare Research and Quality (AHRQ) and from other Federal and state sources. Analysis should be prepared in consultation with dental researchers and might include information on the utilization, cost, cost-effectiveness, outcomes of treatment, measurement of disease and health outcomes. From such data, measures of oral health status including measures specific to gender, ethnic and racial mix of the Medicaid population including children, older Americans and medically compromised patients would emerge.

Conclusion

The ADEA and the AADR are grateful for the opportunity to share our perspective and recommendations for improving state and federal investments in dental programs in Medicaid. We believe that these investments are absolutely necessary to reduce preventable and costly emergency dental care. Our organizations are prepared to work with the Medicaid Commission to help identify programs and policies that expand and enhance access to dental care for them while at the same time providing cost-effective and affordable options that save Medicaid money.

Sincerely,

Eric J. Hovland, D.D.S., M.Ed., M.B.A
ADEA President

Mary MacDougall, Ph.D.
AADR President

Attachments: (1) Academic Dental Institutions as Safety-Net Providers
(2) Fact Sheet: Oral Health and Disease

AMERICAN ASSOCIATION FOR DENTAL RESEARCH

ADEA American Dental Education Association

ACADEMIC DENTAL INSTITUTIONS AS SAFETY-NET PROVIDERS

All 56 U.S. dental schools operate an on-site dental clinic and many provide dental services through other off-site locations through partnerships with state dental programs, community health clinics, private practitioners, Head Start programs, communities of faith, public school health systems, nursing home facilities and private corporations. Some dental schools provide dental services to Medicaid/SCHIP patients through subcontracts with managed care providers and others are expert at leveraging public dollars to acquire private foundation and corporate funding to support dental clinics and the expansion of programs that increase access to dental care in local communities.

Dental school fees are generally lower than those charged for similar services in the private practice community. Overall dental school fees for dental hygiene and undergraduate fees were 50 percent lower while postdoctoral advanced dental specialty programs were 70 percent lower than the usual and customary fees charged by the practice community.

According to a study conducted by the American Dental Association[1], nearly half of all patients treated at dental school clinics were covered by public assistance; a majority of patients have an income of $15,000 or less; and almost all dental schools report receiving revenues from Medicaid. Following are brief highlights of academic dental institution programs that are serving Medicaid and other low-income populations.

University of Tennessee Health Science Center College of Dentistry

The UTHSC College of Dentistry is the largest provider of oral health care in Tennessee's "TennCare" program. The college also provides oral health care for children enrolled in Mississippi Head Start and Arkansas Medicaid. The College of Dentistry provides an average of 40,000 patient visits annually to a diverse patient population including persons with cognitive and other developmental disabilities who reside at Arlington Developmental Center in Arlington, Tennessee and through the Regional Medical Center's Trauma Unit and the outpatient clinic, LeBonheur Children's Medical Center.

Columbia University School of Dental and Oral Surgery

In 2003-04, the dental school provided nearly 120,000 patient visits making it the principle provider of dental care to 325,000 people living in Washington Heights/Inwood and central Harlem communities. The school's Community DentCare Network operates two community comprehensive oral treatment facilities and five school-based prevention clinics in addition to a mobile dental care van. A new initiative to provide oral health care to older Americans has been initiated at the school.

[1] "Study of Dental School Facilities and Programs," American Dental Association, August, 1999.

New York University College of Dentistry

Almost three-quarters (70 percent) of the patients cared for in the dental school's clinic are minority Americans, primarily African-American, Hispanic and Latino subgroups, Asian, and Pacific Islander. Most are desperately poor and many receive Medicaid. In addition, the dental school provides more than $35 million annually in uncompensated care for patients who are unable to pay because they have no insurance or who do not qualify for Medicaid. The school provides free care for over 1,000 homeless children living in shelters and has a cavity-prevention program for children ages 2 to 11. The program provides free fillings for children who follow prevention recommendations and still get cavities. The school also provides education for parents and caregivers, free orthodontic care for poor and minority public school children, and free perinatal education and oral health care for homeless mothers and their infants in community shelters. The school co-founded a regional Oral Cancer Consortium which conducts oral cancer screenings with more than 30 metropolitan-area healthcare institutions and professional societies. Its mobile dental care program, *Smiling Faces, Going Places*, travels daily throughout New York State to Head Start programs, public schools, community health centers or facilities for the developmentally disabled and critically needed dental services to more than 5,000 New Yorkers annually, primarily children, who otherwise would never see a dentist.

Marquette University School of Dentistry

The dental school provides quality care to underserved populations through at least 12 community-based programs throughout Wisconsin in both rural and urban areas. It serves 16,000 patients (over 74,000 patient visits) many from ethnic minorities and 40 percent who qualify for either Medicaid or Medicare. The patients range from pediatric to geriatric in age. The school provides dental care to patients with significant physical or mental disabilities through its Advanced Care Clinic.

West Virginia University School of Dentistry

The dental school's clinics provide services to patients regardless of their ability to pay. The school provides care to patients in community-based settings through its Rural Health Program and has developed oral health education and tobacco awareness programs and delivered them in school systems, senior centers, nursing homes, and at community events. Through the Pediatric Preventive Oral Health Project (PPOHP), the school helped develop user-friendly materials for providers and parents that assess the risk for dental decay in children age 0-3 and educates health providers regarding appropriate oral health interventions and prevention.

AMERICAN ASSOCIATION FOR DENTAL RESEARCH

ADEA American Dental Education Association

FACT SHEET: ORAL HEALTH AND DISEASE

The 2000 Surgeon General's Report, "Oral Health in America," states that "Oral health is a critical component of health and must be included in the provision of health care and the design of community [health] programs."[1] The report documents the burden of oral diseases as disproportionate among the U.S. population. Reports from the General Accounting Office (GAO) and the National Governors' Association (NGA) corroborate these findings.

The number of Americans without health insurance at 48 million dwarfs in comparison to the 108 million Americans without dental insurance. The problem will get worse as reductions in private health insurance coverage for dental benefits increases. An August 2003 accounting periodical reported that certified public accounts should advise their clients and employers to minimize health care costs by dropping "coverage entirely in peripheral areas such as dental and vision plans." The article goes on to say, "…employees tend to regard such plans as less necessary than medical coverage, which makes cutting them less likely to cause employee animosity."

Many older Americans lose their dental insurance when they retire. Even though approximately 23 percent of persons age 65 to 74 have severe periodontal disease and 30 percent of adults are completely toothless. Prescription medications taken by older adults have side effects such as dry mouth that increase their risk for oral disease. Medicare does not reimburse for routine dental care and screenings for older adults. Often, it is only after a dental condition sufficiently deteriorates resulting in a medical problem that an older person receives dental treatment.

Oral and pharyngeal cancers are more common than cancers of the brain, liver, bone, stomach, cervix, ovaries and leukemia and are diagnosed in 30,000 Americans annually. Approximately 8,000 people die from these diseases each year, even when if detected early, these diseases are over 90 percent curable.

Children and families living below the poverty level experience more dental decay and are much less likely to seek treatment. Tooth decay is the most common chronic childhood disease—5 times more common than asthma. Children below 200 percent of poverty have three times the tooth decay of children in more affluent homes. The problem is worse for children of color.

More than 51 million school hours are lost each year to dental-related illness. Pain and suffering due to untreated dental disease can lead to problems in eating, speaking and impact a children's ability to concentrate and learn. It can affect a person's ability to function and reduce employment options and limit economic productivity of working adults. Dental disease also complicates medical conditions such pregnancy (has been linked in studies to pre-term low-birth weight babies), diabetes, and heart disease.

State support for oral health care is limited. Not only are Medicaid dental programs under-funded in a majority of states, but are first to be cut in times of economic hardship. In recent years, more than 16 states have reduced or eliminated optional dental benefits for adult Medicaid recipients and several have also reduced Medicaid reimbursement rates to dentists. Problems accessing dental care for low-income and underserved people have reached crisis proportions as there is no dental equivalent to the medical "safety-net" in states.

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[1] Oral Health in America: A report of the Surgeon General, Rockville, MD, National Institutes of Health, National Institute of Dental and Craniofacial Research, U.S. Department of Health and Human Services 2000.