

July 1, 2004

Carolyn M. Clancy, MD  
Director  
Agency for Healthcare Research and Quality  
John M. Eisenberg Building  
540 Gaither Road  
Rockville, MD 20850

**Re: Docket I.D. 2004S-0170 – Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 1013: Suggest Priority Topics for Research in FY 2006 [69 Fed. Reg. 22045-22047].**

Dear Dr. Clancy:

The dental community is interested in expanding the Department of Health and Human Services' health services research efforts on oral and dental health issues and is pleased to provide comments in response to the request to identify priorities for research, demonstration and evaluation projects to support and improve Medicaid and the State Children's Health Insurance Program in FY 2006. While we recognize that priority consideration will be directed toward the evaluation and effectiveness of prescription drugs in order to meet the terms of the statute (Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), we urge the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid Services (CMS), and other agencies as appropriate, to consider oral health research as a subsequent priority.

While dental services are a small portion of the federal Medicaid and SCHIP budgets, these services are a continual target for budget cuts – cuts that have an immediate and devastating effect on the health of our most vulnerable citizens and long lasting consequences. These cuts are largely counterproductive because underfunding and/or eliminating public oral health programs for children and adults results in higher budgetary costs and worse health outcomes. Without adequate access to oral health services, individuals are forced to turn to emergency rooms for immediate relief of pain and suffering. The cost of providing this relief far exceeds the cost of providing preventive dental care and treatment services. Children with devastating oral disease grow up to be adults who are unable to obtain gainful employment partly due to the effect of poor oral health on appearance, or chronic oral pain that limits their ability to function. When seeking to identify research priorities that impose high costs on Medicaid or SCHIP, the agency steering committee should recognize that while overall and upfront dental public program costs are low, the steady growth of dental disease within underserved populations and the associated health care consequences impose a much higher price tag on society.

Today, dental decay is the most prevalent chronic disease of childhood, yet according to state-reported data gathered by CMS, overall utilization of dental care by underserved children in public programs is less than one in five. This is true despite the fact that federal law requires states to cover dental services for Medicaid-eligible children through the Early, Preventive, Screening, Diagnostic, and Treatment program (EPSDT).

Limited access to dental care is a major healthcare issue today, and the dental profession is trying to do its part to improve care for the underserved. However, like other health professions, dentistry is facing challenging times when it comes to addressing the needs of those served by Medicaid and SCHIP. Since 2003, the profession has been confronted with:

- The prospect of the nation's dental schools being forced to eliminate more than 500 non-hospital-based dental residency training programs that help provide practitioners to underserved communities. A 2003 final rule, promulgated by the Centers for Medicare and Medicaid Services, eliminated Graduate Medical Education (GME) funding for most existing dental residency programs in non-hospital locations.
- A continuum of budget proposals to eliminate funding for Title VII (Public Health Service Act) pediatric, general and public health dental residency training programs, which help provide practitioners to underserved communities.
- The elimination or reduction of adult dental benefits across the states - affecting access to dental care, especially for the frail elderly.
- Restrictions in Medicaid and SCHIP enrollment and eligibility for children, reducing access to oral health care.
- Reductions or a freeze in Medicaid reimbursement to practitioners, when most states already do not adequately reimburse to cover the cost of care provided to Medicaid beneficiaries.

The challenge to provide dental services to the underserved will only be exacerbated as health care programs face further budgetary restrictions. Several states have been working to enhance their programs by establishing public-private partnerships and testing new innovations to improve access to dental services. Several of these innovations could serve as models for other states; however, evaluation of these programs has lagged due to limited resources.

Recognizing the challenges faced by the dental profession in providing care to Medicaid and SCHIP beneficiaries, the undersigned organizations encourage AHRQ and other agencies of HHS to consider the following dental health services research areas as priorities, and strongly urge AHRQ to incorporate dental considerations into current and planned non-dental projects.

1. An evaluation and comparison of state-based dental Medicaid innovations that have sought to improve dentist participation in the Medicaid program and increase utilization of services by mirroring programs within the commercial dental benefits sector. Two states have reformed their dental Medicaid program by contracting with a single vendor to administer the dental program in the same way they administer their private insurance program. At least four additional states have established unique comprehensive programs to address all of the barriers dentists and communities have traditionally identified within the Medicaid program: inadequate program reimbursement, administrative complexities, high rates of broken appointments and lack of oral health literacy within the patient population. These states have sought to improve the way the dental Medicaid program is administered, managed and delivered. Initial results demonstrate improvements in access to dental care. Many other states have implemented program reforms with little-to-no success; believed to be as a result of focusing on limited programmatic reforms as

opposed to a comprehensive reform approach. More in-depth evaluation is needed to determine the cause and effect programmatic reforms have on access to care within dental Medicaid programs and outline the estimated resources needed for a state to develop and sustain program improvements.

2. An evaluation of the effects of a CMS final rule, effective in October 2003, which virtually eliminated Medicare direct GME and IME payments for dental residency training programs in non-hospital settings. Previously, Congress had provided incentives for moving dental residency training programs into community settings through affiliations with hospitals (*Omnibus Budget Reconciliation Act of 1986; Balanced Budget Act of 1997*). These provisions offered opportunities to enhance support for financially struggling programs that are significant in the care of indigent and underserved populations and crucial in the training of dentists. Prior to CMS's final rule, approximately two-thirds of the nation's 56 dental schools received GME funding for resident training in non-hospital locations. The dental profession is concerned that the elimination of most of the existing training programs will jeopardize the training of thousands of future dental residents and severely limit access to necessary oral health services for indigent and underserved populations provided by residents in non-hospital locations. An evaluation is necessary to determine, for example, the significance these cuts have on access to care and whether such cuts result in a career shift for dentists, in terms of which dental specialties they select, and whether they choose to establish dental practices in underserved locations.
3. Studies on the effect of incentives (i.e., state tax credits, loan repayment and scholarship programs), if any, on increasing dental provider participation in Medicaid and SCHIP, particularly in underserved communities. Several federal and state programs have employed this strategy to improve the distribution of dentists within states and communities and increase access to dental services. An evaluation would assist in determining whether these incentives are cost effective and do improve the recruitment and retention of dental providers within public programs.
4. An examination of whether a correlation exists between the graduating student loan indebtedness of dentists and dentist participation in Medicaid and SCHIP. Dentists are small business owners, and practices differ considerably from medical practices with much higher overhead costs (approximately 65-70 percent of overall practice revenues). One of the identified limitations to dentist participation in public programs, as outlined in past reports by the HHS Office of Inspector General and the U.S. General Accounting Office is inadequate reimbursement within public programs. The location of dental offices is largely based on market indicators that signify patient demand for services and where a dentist can operate an effective dental practice with adequate compensation for services, given the costs of sustaining that practice. Establishing a practice in an underserved area and treating Medicaid or other public program beneficiaries may be viewed as an economic disadvantage for new dentists who have a significant volume of educational debt.
5. Research to determine the effectiveness of non-dental provider collaborations to improve access to preventive dental services for infants and young children (i.e., to prevent the

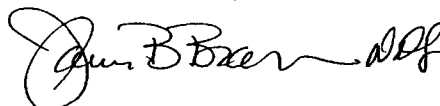
onset of early childhood caries). With the assistance of federal grant support, a few states have begun to test models to determine how primary care physicians and other medical personnel who interact with children on a more frequent basis than dentists can assist in providing educational oral health information and basic health services to promote oral health and prevent dental disease. Such efforts have also sought to improve referral rates to dentists to guarantee comprehensive oral health care treatment is available to children most at risk for dental disease. Further evaluation of such programs is needed.

The undersigned dental organizations appreciate AHRQ's and the HHS steering committee's consideration of our comments. Should you have any questions, please contact Julie Allen, Manager, Legislative and Regulatory Policy at the American Dental Association at (202) 789-5177 or Gina Luke, Director of Policy Development at the American Dental Education Association at (202) 667-9444.

Sincerely,



Eugene Sekiguchi, DDS  
President  
American Dental Association



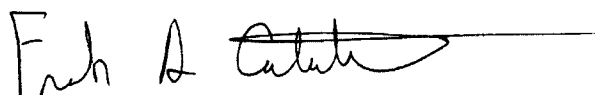
James B. Bramson, DDS  
Executive Director  
American Dental Association



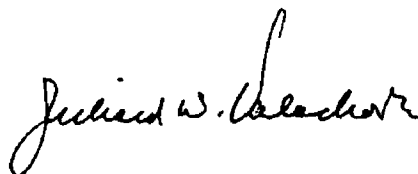
Christopher H. Fox, DMD, DMSc  
Executive Director  
American Association for Dental Research



Amid Ismail, BDS, MPH, DrPH  
Chair, National Affairs Committee  
American Association for Dental Research



Frank A. Catalanotto, DMD  
President  
American Dental Education Association



Richard W. Valachovic, DMD, MPH  
Executive Director  
American Dental Education Association