
**Statement of the**
**American Dental Education Association (ADEA)**

**Presented by**
**Frank A. Catalanotto, D.M.D.**
**Chair**
**Department of Community Dentistry and Behavioral Science**
**at the University of Florida College of Dentistry**

**Domestic Policy Subcommittee**
**Oversight and Government Reform Committee**

**Wednesday, October 7, 2009**
**2154 Rayburn HOB**
**2:00 p.m.**

My name is Frank Catalanotto. I am a Professor and Chair of the Department of Community Dentistry and Behavioral Science at the University of Florida College of Dentistry. I am here today on behalf of the American Dental Education Association (ADEA)[i]. ADEA's membership of academic dental institutions serve as dental homes for a broad array of racially and ethnically diverse patients many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their health care.

The American Dental Education Association is grateful for this opportunity to share our perspective and recommendations for improving children's dental programs in Medicaid. We believe that a strong dental program within Medicaid is essential to reducing preventable and costly emergency dental care. ADEA and its members are doing all they can with shrinking budgets and limited resources to improve access to dental care for low income and disadvantaged children. We are ready to work with the members of this Committee and with Congress to address both the access and fiscal problems affecting children's access to dental care in Medicaid.

In my testimony, I will provide you with an overview of the context in which children's dental disease exists in our nation, with some specific ways in which ADEA's members are striving to address access problems and finally offer recommendations regarding some actions that Congress can take to improve children's access to dental care.

## Dental Disease Burden and Children's Oral Health Disparities

The Surgeon General's report declared dental caries (tooth decay) to be one of America's most widespread infectious diseases, five times more common than asthma and seven times more common than hay fever in school children. Cleft lip/palate is one of the most common birth defects.

The burden of dental disease, in terms of both extent and severity, has shifted dramatically to a subset of our children. About a quarter of the population now accounts for about 80 percent of the disease burden. Native American, Alaska Native, Hispanic and African-American children are far more likely to have untreated dental caries than Caucasian children.[ii] Dental caries also remains a significant problem for children with special care needs.

### Examples of Children's Oral Health Disparities

- The rate of tooth decay for Hispanic toddlers is 4.5 times that of Caucasian children.
- The rate of tooth decay among American Indian and Alaska Native children is 3 to 4 times that of the rest of the population.
- African American children are 40% less likely to have preventive dental sealants.
- African American children are more likely to have their teeth extracted than white children.
- Almost twice as many Hispanic children (40%) as Caucasian children have untreated tooth decay.
- Rates of untreated tooth decay for American Indian and Alaska Native children are 3 times higher than the rest of the population.

- Children and adolescents with special health care needs are 2 times as likely to have unmet oral health care needs across all income levels.
- Parents of children with disabilities consistently report dental care as one of the top needed services regardless of age.

## Children's Access to Dental Care

Nine million children lack health insurance coverage but three times as many (20 million) have no coverage for dental services. Even those with coverage may experience problems accessing dental services as many still do not have access to dental services because of a lack of dental providers in their communities. Over 4,000 counties or partial counties have been designated dental Health Professions Shortage Areas (D-HPSA) where individuals suffer from an absolute lack of dental providers. Less than half of these communities are served by safety-net providers.

Unlike medicine (in which 75 percent of physicians accept patients on public programs such as Medicaid and the Children's Health Insurance Program) only about 25 percent of practicing dentists see patients enrolled in public programs. In Florida, only 10 percent of dentists participate in the state's woefully underfunded Medicaid program. States often have difficulty enrolling participating dentists in public programs such as Medicaid and SCHIP because reimbursement rates are one-half to one-third of fees in private dental practice.[iii] Dentists are also resistant to the burdensome administration of the public system which often varies greatly from private dental insurance.[iv] Consequently, millions of children enrolled in publicly insured programs that are entitled to dental services experience difficulties receiving care.

These factors were at play in the case of 12-year-old Deamonte Driver whose mother could not find a dentist to treat her son before his tooth infection spread to his brain and tragically resulted in his death. His death could have been avoided by simply removing his tooth, a procedure costing about $80. Though covered by Medicaid, neither the boy's family or legal aid attorney were able to find a dentist willing to take new Medicaid patients. The consequences of not having access to oral health care can be severe and fatal.

Access problems will grow too, as large numbers of dentists retire during the next 10 to 15 years. The looming retirement of aging dentists is expected to occur at a 2 to 1 ratio to the number of new dentists graduating over the next decade.[v] Growth among minorities is increasing the need to recruit and train a more diverse dental workforce. By the year 2050, nearly one in five Americans (19 percent) will be an immigrant, compared with one in eight (12 percent) in 2005. Despite these population trends, minorities are underrepresented in the U.S. health care workforce. This is no less true of dentistry, where they comprise less than five percent of dentists and about nine percent of dental faculty.

**Demographic Trends**

- Minorities will grow from 1/3 of the U.S. Population to over ½ (54%) by 2050.
- In 2050, 235.7 million U.S. residents will be minorities.
- The largest growth will be in the number of Hispanic/Latinos doubling to 30 percent (132.8 million).
- By 2030, minorities will comprise more than one-half of all children.

## An Inadequate Dental Safety-net

The nation's dental safety-net is a loosely organized spattering of clinics and providers that have limited access to health information technologies, electronic health records and other tools to operate at optimum capacity. Safety-net dental programs in community health centers, local health departments, and academic dental clinics at full capacity are able to meet only about eight percent of all unmet dental needs.

Many safety-net dental clinics also experience significant gaps in their capacity to provide comprehensive dental services. As a result, academic dental clinics, particularly those situated on campuses, are often a major source for a full range of specialty dental services and often the most complex cases are treated there. Unlike other safety-net providers, such as hospitals and community health clinics, there are few public subsidies available to academic dental institutions to help pay for the uncompensated dental care they provide.

## Impact of the Economy on Medicaid Dental Benefits

The economic downturn has affected almost every state budget. Forty-eight states reported budget shortfalls for fiscal year 2010[vi]. Medicaid continues to challenge budgets as enrollment increases with the loss of jobs in states and more individuals are forced to seek Medicaid coverage with the loss of their employer-sponsored health insurance coverage. Medicaid accounts for more than 20 percent of total state spending and continues to outpace state spending on all other programs except for K-12 education.

Medicaid dental programs are already woefully underfinanced, accounting for only about 1.5 percent of all Medicaid expenditures ($5 billion of the $329.4 billion spent on Medicaid in 2007). Medicaid dental reimbursement levels have also been historically low; on average, they equal the lowest 10 percent of market rates in many states.[vii] Sadly, states continue to look to cut Medicaid dental benefits in difficult economic times.

Since 2008 fifteen states have made dental cuts. Some of these cuts have affected children's dental benefits by lowering annual caps on payments for dental services, restricting or eliminating certain procedures (including dental surgery), and cutting fees to providers which have even forced safety-net dental clinics to close their doors. Medicaid program cuts continue to impact low-income children's access to dental care. Without sufficient access to dental care in Medicaid, millions of low-income families opt to postpone needed dental care until a dental emergency occurs requiring immediate, more complicated and more expensive treatment.

## Medicaid: Still an Important Dental Safety-Net

Despite the problems associated with financing and access to dental care, Medicaid is still a major source of care for approximately one-quarter of all children and half of the nation's poor children. All 29 million children in Medicaid are eligible for needed dental care through the Early Periodic Screening, Diagnosis and Treatment program (EPSDT). In 2006, 73 percent of children aged 2-17 with public coverage had a dental visit during 2005, compared with only 48 percent of uninsured children. [viii]

Programs like EPSDT that provide early preventive dental treatment for children result in costs that are 40 percent lower[ix] than when their oral health is neglected. For example, in Florida from July 2006 through June 2007, 196 Medicaid recipients under age six were admitted to hospitals for an average of 3.7 days for life-threatening dental infections[x] Early prevention for these patients could have saved the Medicaid system more than one million dollars—not counting parents' lost time at work.[xi] According to another report by the California Dental Health Care Foundation, the number of emergency department visits for preventable dental conditions is growing at a faster rate than the state's population. The rate of preventable dental admissions is twice that for diabetes and asthma.

## The Role of Academic Dental Institutions in Improving Access

U.S. academic dental institutions (ADIs) are the fundamental underpinning of the nation's oral health. ADIs play an essential role as major contributors to the dental safety net, in conducting research and unveiling scientific evidence that leads to improvements in oral health, and in educating and training the future oral health workforce. Academic dental clinics serve as key referral resources for specialty dental services not generally accessible to Medicaid and SCHIP patients. ADIs provide care at reduced fees and provide millions of dollars of uncompensated care in their clinics each year. States look to ADIs for assistance in administering and supporting a variety of community dental programs including school-based sealant programs and assessments of dental workforce needs.

All 59 U.S. dental schools operate clinics that teach students how to treat a broad array of patients and conditions as part of their educational mission. All dental residency training programs provide care to patients through dental school clinics or hospital-based clinics and all dental hygiene education programs operate on-campus dental clinics where classic preventive oral health care is provided four to five days per week in compliance with state practice acts.

### Snapshot of Patient Care Provided Through Dental Schools

- On average 53,298 patient visits were conducted annually per U.S. dental school through on-campus and extramural facilities (2005-06).
- On average 6,106 dental screenings were provided annually per U.S. dental school (2005-06).
- 81% of all U.S. dental schools in 2005-06 offered clinical training opportunities at off-campus locations.

A report by the American Dental Association on dental school community-based clinics found that public assistance programs, such as Medicaid and Medicare, cover about 50 percent of patients seen at academic dental clinics. Almost one-third of patients (32 percent) had no dental insurance coverage. Over 65 percent were members of families with annual incomes of less than $15,000 (1998) and 41 percent of patients were under the age of 14.

**Community-Based Service Learning**

Community-based rotations have been successful in increasing access to dental care by placing dental students and faculty in settings that reach underserved communities. Community-based clinical experience refers to students who provide patient care in community-based clinics or private practices. Over 92 percent of all dental curricula require community-based clinical experiences.[xii] Creating partnerships between academic dental institutions and community-based programs helps increase the number of clinics able to address the underserved community's oral health needs. Community clinics are usually more convenient for patients who do not have to travel long distances for their care.

Surveys have shown that students who complete rotations in underserved communities during their dental education tend to include these populations in their patient mix after they graduate and become practicing dentists.[xiii] During community rotations, students get a lot of experience working with a diverse patient mix, including pediatric, minority, geriatric, and special needs patients. Through exposure to this diverse patient mix, dental students expand their clinical training experiences, increase their cultural competency, and gain an understanding of their social responsibility as health care professionals. They understand the extent of the need for care among those who are underserved because they have seen it first-hand. When dental students graduate they feel competent to address the oral health needs of underserved populations in their communities.

Community-based dental education is an effective method of educating dental students.[XIV] Students enjoy community rotations for the opportunities they provide to learn in an integrated care setting and to familiarize themselves and become comfortable treating a diverse patient population. Below are some examples of academic dental institutions efforts to increase access and enhance student care experiences through community-based dental education programs.

**1) The Robert Wood Johnson Foundation and The California Endowment funded the *Pipeline, Profession & Practice: Community-Based Dental Education program* (Dental Pipeline)**. This program, which began in 2002, has four main goals: 1) to increase services provided to vulnerable populations through dental school community-based collaborations; 2) to train graduates with the cultural knowledge and communication skills they need to treat racially and ethically diverse patients; 3) to increase student body diversity; and 4) to graduate more dentists who choose to practice in communities-of-need. The first round of grants were distributed in 2002, and the second round in 2008. In order for dental schools to be eligible for funding, they had to establish community-based clinical education programs; revise their curriculum to incorporate community-based practice experience into their educational programs; and implement programs to increase recruitment and retention of underrepresented minority and low-income students. The results with regard to community-based education have been very positive.

**A Snapshot of Dental Pipeline**

- 344 facilities participated in the RWJ/TCE Pipeline program
- 63 percent of facilities were in rural areas
- FQHCs participating in program grew from 28 (14 percent) to 76 (22 percent)
- dental students provided 128,936 services in underserved communities
- 68,636 patients (55 percent were African American, Hispanic or Native American)
- 25,937 patients were seen as part of these extramural rotations in Federally Qualified Health Centers (FQHCs)

**Program Participants**

| 2002-2007 | 2008-2010 |
|---|---|
| Boston University | A.T. Still University of Health Sciences |
| University of Connecticut Health Center | Creighton University |
| Howard University | Texas, A&M Health Science Center |
| West Virginia University | Medical College of Georgia Research Institute, Inc. |
| University of North Carolina at Chapel Hill | The University of Maryland Baltimore |
| Meharry Medical College | University of Florida |
| University of Illinois at Chicago | University of Medicine and Dentistry of New Jersey |
| The Ohio State University | Virginia Commowealth University |
| University of Washington | |
| University of California at San Francisco | |
| Temple University | |
| University of California at Los Angeles | |
| University of the Pacific | |
| University of Southern California | |
| Loma Linda University | |

**2) The University of Florida College of Dentistry (UFCD) Statewide Network for Community Oral Health**. This program began in 1997 to increase access to oral health services for underserved populations in Florida and provide more learning environments for students and residents. UFCD began the program through partnerships across the state. UFCD now owns five dental clinics and is affiliated with another nine clinics, including federally qualified community health centers, county health departments and a mobile dental van. Students and residents offer services in these clinics and complete rotations throughout the state in a variety of settings affiliated with the Department of Health, community health centers, or private or non-profit entities. The Network provides comprehensive dental care, emergency services, hospital-based treatment, and preventive dental services and education for children and adults throughout Florida. It serves Florida's most vulnerable populations and provides care in areas of great need.

**UFCD Statewide Network for Community Oral Health (2008)**

101,686 patient visits
25,552 children's visits
76,134 adults
80,835 of patients seen (76%) live at or below 200% of federal poverty
18,742 of children seen (74%) were at or below the poverty level

Upon review of Medicaid statistics in Florida, it is clear that although Medicaid is the program serving low-income and vulnerable populations, there are issues to be

addressed to ensure their access to care. Only about 26 percent of Medicaid recipients receive dental services. Only 10 percent of children under age six receive any dental services. The ratio of Medicaid dentists to eligible children in Florida is 1:7,610. Until these Medicaid numbers change, UFCD Statewide Network of clinics, students, and residents will remain a primary source of dental care for the poor and underserved in Florida.

3) **Ohio State University's Oral Health Improvement through Outreach [OHIO] Project**. This Ohio State University (OSU) College of Dentistry (COD) program is part of the dental pipeline. It focuses on recruitment of underrepresented minority students, curricular changes, and extramural clinical rotations. When the College of Dentistry submitted the proposal to the Robert Wood Johnson Foundation, the state had already identified oral health as its top unmet health care need. Access to dental care is a significant problem in Ohio especially for urban poor and minority populations including African Americans, immigrant Asians, Hispanics, Somalis, disabled children and adults, and the rural Appalachian poor. While 11 percent of Ohioans are uninsured for health care, 41 percent (4.6 million people) do not have coverage for dental care.[xiv] The College of Dentistry's goal in the Pipeline program was to reach populations in need of dental care. Starting from four rural and six urban sites in 2003, the OHIO Project has expanded to include seventeen rural and twenty-nine urban sites in 2007. In 2003, thirteen students were sent on rotations for a total of five days; by 2007, the entire fourth-year class was going on rotations and spent nearly sixty days in community rotations.

## The Role of the Federal Government: Recommendations for Improving Children's Access to Dental Care

Academic dental institutions have a reciprocal relationship with Medicaid in accessing funding for, and providing services through, dental education programs that treat underserved populations, including those on Medicaid. The strong role that ADEA member institutions serve as major dental safety-net providers, combined with the broad range of oral health policy expertise and interests we represent, qualify ADEA to offer the following recommendations to improve access to dental care for children enrolled in Medicaid.

1) **Preserve eligibility for the full scope of dental services available under the EPSDT program for children in Medicaid.** Any plan that would substitute the eligibility or benefit standards under EPSDT will weaken critical dental services for millions of children. Alternatives to EPSDT would not reduce states' health care costs. Rather, they would significantly drive up costs by replacing cost-effective preventive care provided by EPSDT with more costly emergency treatment.

2) **Fund the Expansion of Community-Based Service Learning Programs Within Academic Dental Institutions.** Provide funding for programs that increase access to oral health care through collaborative partnerships between state Medicaid programs, community health centers and academic dental institutions. Academic dental institutions have been innovative laboratories for community-service learning programs that increase access to dental care for low-income and vulnerable populations. Academic dental institutions 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.

**3) Provide a Federal "dental disproportionate share" (DDS) payment** to academic dental institutions (ADI) and other dental safety-net providers that serve large numbers of underserved children who are at a higher risk for acute dental disease. Academic dental clinics are well-equipped to meet the needs of large numbers of underserved children whose dental care has been neglected and whose conditions as a result are often complex. DDS payments will ease the costly burden facing ADIs when Medicaid or SCHIP reimbursement rates are artificially low and when they are not reimbursed at all for services to uninsured children.

4) **Provide Federal funds to states for school-based oral health promotion, education and prevention programs**. Provide Federal funding to States and Indian Tribes for the development and implementation of school-based oral health promotion and disease prevention programs. Eligible schools must be located within an area that is designated as dentally underserved or in rural or urban settings when 50 percent of students are eligible for Medicaid or SCHIP. Funds would be used to enable schools to provide children with basic education, prevention and emergency dental care by licensed dental professionals within their scope of practice.

5) **Increase funding and support for Federal Programs that are critical to building the primary care dental workforce such as the Title VII General and Pediatric Dentistry Programs.** Support for these programs is essential to expanding existing or establishing new general dentistry and pediatric dentistry residency programs, which have shown to be effective in increasing access to dental care for vulnerable populations, including patients with developmental disabilities, children, and geriatric patients. These primary care dental residency programs generally include outpatient and inpatient care and afford residents an excellent opportunity to learn and practice all phases of dentistry, including trauma and emergency care, and comprehensive ambulatory dental care for adults and children.

6) **Develop standards and protocols for models of care that allow primary care professionals to gather data, detect clinically apparent pathologic conditions, triage and refer patients to appropriate dental professionals for care**. 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 and identifying dental disease. Dental schools and oral health professionals could serve as oral health team leaders providing the necessary guidelines for 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 other allied dental professionals.

7) **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 agencies. 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 that are specific to age, gender, ethnic and racial mix of the Medicaid population including children, older Americans and medically compromised patients would emerge.

8) **Oral Health Benefits in Health Care Reform.** The House Tri-Committee (HR 3200) and the Senate HELP health care reform bills include provisions that require oral health services for children. The Senate bill establishes an "Affordable Health Benefit Gateway" through which individuals and specified businesses can purchase insurance. All plans that participate in the program *must include oral health benefits for children*. Likewise, the House reform proposal establishes a "Health Insurance Exchange" program through which individuals and specified businesses can buy insurance. All plans that participate in the program *must include oral health benefits for children*. The American Dental Education Association (ADEA) strongly supports these provisions. Including access to oral health care for children is vital to ensuring that children grow up strong and healthy.

However, adults also need access to and coverage of oral health care services as a basic benefit. (The House Tri-Committee legislation would allow only for an optional adult oral health benefit at an additional cost in its "premium-plus" benefit package.) As health care reform legislation is aimed at helping those most in need, dental care cannot be forgotten. ADEA is committed to the proposition that every American should have access to and coverage of affordable diagnostic, preventive, restorative, and primary oral health care services so as to eliminate pain, suffering, and infection.

## Conclusion

Academic dental institutions have a human and financial stake in preserving the basic foundation and funding of the Medicaid program and in ensuring that the nation's youngest, poorest and sickest citizens have access to basic and preventive oral health services. ADEA believes it is critical for Congress to preserve basic services for Medicaid beneficiaries and safeguard essential Medicaid dental benefits in any reform of the U.S. Health Care system.

ADEA and its member institutions are prepared to work with Congress and other oral health advocates to identify programs and policies that will increase access to dental care for underserved children in Medicaid through cost-effective and affordable means.

---

[i] The American Dental Education Association represents all 59 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided. ADEA member institutions serve as dental homes for a broad array of racially and ethnically diverse patients, many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their health care.

[ii] U.S. Department of Health and Human Services. *The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001*, Health Resources and Services Administration, National Center for Workforce Analysis Bureau of Health Professions, Washington, D.C., April 2004

[iii] Moskowitz, M.C., *State Actions and the Health Workforce Crisis*, Association of Academic Health Centers, Washington, D.C., 2007.

[iv] American Dental Association, *Increasing Access to Medicaid Dental Services for Children Through Collaborative Partnerships*, Washington, D.C., March 2004.

[v] Beazoglou T., Bailit H., Jackson-Brown L, *Selling Your Practice at Retirement: Are There Problems Ahead?,* Journal of the American Dental Association, December 2000, 131(12):1693-1698.

[vi] Center for Budget and Policy Priorities, Lay, IJ, McNichol, E. "New Fiscal Year Brings No Relief From Unprecedented State Budget Problems," September 3, 2009.

[vii] Crall, J. and Schneider, D., with American Dental Association (Ed.). *Medicaid reimbursement: Using marketplace principles to increase access to dental services*. 2004.

[viii] Paradise J, Dental Coverage and Care for Low-Income Children: The role of Medicaid and SCHIP, The Kaiser Commission on Medicaid and the Uninsured, July 2008.

[ix] Sinclair, S., Edelstein B. *Cost effectiveness of Preventive Dental Services*. Washington, DC. Children's Dental Health Project, February 2005.

[x] Shenkman, E.A., Chair, Department of Epidemiology and Health Policy, University of Florida (presented by Frank Catalanotto to the Florida legislature, July 2008.)

[xi] Lee et al. *Examining the cost-effectiveness of early dental visits*. Pediatric Dentistry 2006; 28(2):102-105, 192-198.

[xii] American Dental Association, Survey Curriculum – 2006-2007.

[xiii] Baumeister SE, Davidson PL, Carreon DC, Nakazono TT, Gutierrez JJ, Andersen RM. What influences dental students to serve special care patients? Spec Care Dent 2007;27(1):15–22.

[XIV] DeCastro JE, Bolger D, Feldman CA. Clinical competence of graduates of community-based and traditional curricula. J Dent Educ 2005;69(12):1324-31.

[xiv] ADEA *Journal of Dental Education. Volume 73, Number 2 Supplement* February 2009