

ADEA Member Testifies on Capitol Hill

On Wednesday, October 7, the House Subcommittee on Domestic Policy of the Committee on Oversight and Government Reform held a hearing, "Medicaid's Efforts to Reform since the Preventable Death of Deamonte Driver: A Progress Report." The hearing focused on access to pediatric dental services in Medicaid and aimed to understand innovative programs that increase the number of children obtaining these services.

Frank A. Catalanotto, D.M.D., Professor and Chair of the Department of Community Dentistry and Behavioral Science at the University of Florida College of Dentistry, and ADEA Past President testified on behalf of the American Dental Education Association (ADEA). His remarks focused on the oral health services that dental schools and dental hygiene programs provide to children. He highlighted the University of Florida College of Dentistry (UFCD) Statewide Network for Community Oral Health, a program that increases access to dental services by utilizing dental students and residents to provide care in underserved areas. The services are provided in school-owned and operated clinics, but also in affiliated clinics around the state. He brought to the attention of the Chairman, Representative **Dennis Kucinich** (D-OH), and members of the Subcommittee the *Pipeline, Profession & Practice: Community-Based Dental Education* program (Dental Pipeline), a Robert Wood Johnson Foundation and The California Endowment funded program, that aims to increase community-based rotations of students to increase access, provide students with the cultural competency skills they need to provide services to a diverse patient base, increase the number of underrepresented minorities in the student body, and graduate more students who want to work in underserved areas. (See Dr. Catalanotto's complete testimony on page 13.)

Other witnesses included Dr. **Burton L. Edelstein**, Chairman, Children's Dental Health Project; Dr. **Mary G. McIntyre**, Medical Director, Office of Clinical Standards and Quality, Alabama Medicaid Agency; and Dr. **Joel H. Berg**, Chairman, Department of Pediatric Dentistry, University of Washington. Ms. **Cindy Mann**, Director, Center on Medicaid and State Operations, and Ms. **Katherine Iritani**, Assistant Director, Health Issues, Government Accountability Office, were government witnesses.

Appropriations 2010

The House of Representatives has approved its version of the FY 2010 Labor-HHS-Education Appropriations bill (H.R. 3293). Previously, the Senate Appropriations Committee voted 29-1 on its bill, but no date has been set for a full Senate vote.

The Senate Committee's bill provides \$460.1 million for the health professions programs, including \$243.4 million for Title VII and \$216.7 million for Title VIII. Within these totals, for Title VII the bill provides the President's proposed increases for the Health Careers Opportunity Program (HCOP) and the Centers of Excellence (COE) diversity programs, as well as increases over FY 2009 for the Allied Health (graduate psychology) and Public Health, Preventive & Dental Public Health programs. Additionally, for the first time since FY 2005, the bill provides funding (\$5.7 million) for the Health Workforce Information and Analysis program.

The House-approved bill provides \$529.7 million for the health professions programs, including \$266.3 million for Title VII. (See chart on page 11.)

President Signs Continuing Resolution

President **Barack Obama** has signed a Continuing Resolution (CR) to keep most federal agencies and programs operating at FY 2009 funding levels through the end of October, while

Congress completes work on the 12 annual spending bills. To date, the House has approved all its spending bills, while the Senate has approved six.

ADEA Meets with Presidential Appointees

On August 4, representatives of the American Dental Education Association (ADEA), the American Academy of Pediatric Dentistry (AAPD), and the American Dental Association (ADA) met with **Mary Wakefield**, Ph.D., R.N., FAAN, the new Administrator of the Health Resources and Services Administration (HRSA). Dr. Wakefield was the Associate Dean for Rural Health at the University of North Dakota School of Medicine and Health Sciences. She has served as a member of the Medicare Payment Advisory Commission and the Department of Veterans Affairs' Special Medical Advisory Group, the Chair of the Institute of Medicine Committee on Health Care Quality for Rural America, and a Subcommittee Chair for President **Bill Clinton's** Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

The agenda for the meeting and the conversation with Dr. Wakefield and her senior staff were wide-ranging and included such issues as HRSA's support for its chief dental officer; the need to update HRSA's tracking of dental workforce data; the status of program administration and the need for experienced program officer support for the Title VII pediatric and general dentistry residencies programs; the administration of state oral health access grants, especially for the Dental Health Improvement Act; the Ryan White AIDS dental reimbursement program; and the impact of American Recovery and Reinvestment Act (ARRA) stimulus funds for the National Health Services Corps (NHSC) on the recruitment of dentists and dental hygienists.

The dental coalition urged the Administrator to revitalize the ten HRSA regional dental consultant positions and informed her of the need to update HRSA's oral health guidance for and data on oral health grantees. In discussing the concept of a "dental home" and agreeing with the coalition on its importance, Dr. Wakefield stressed the need to keep the patient at the center of the health care system. She stated that that concept anchored her approach to fulfilling the responsibilities of her new position and suggested that providers of medical and oral health care services should focus on a "health home" for every patient. She also urged oral health care providers, when possible, to consider working part-time in the National Health Services Corps.

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On August 5, ADEA representatives met with **David Blumenthal**, M.D., M.P.P., National Coordinator for Health Information Technology (HIT). Before his appointment by President Obama, he was the Director of the Institute for Health Policy at the Massachusetts General Hospital/Partners HealthCare System in Boston. Prior to that, he was Samuel O. Thier Professor of Medicine and Professor of Health Care Policy at Harvard Medical School. As the HIT czar, Dr. Blumenthal oversees \$19.5 billion included in the American Recovery and Reinvestment Act (ARRA).

ADEA's primary message was that the HITECH Act for all practical purposes overlooks providers of oral health care services and their patients with respect to the funding, implementation, and operation of the nation's HIT infrastructure. While dental school clinics are not directly eligible for ARRA stimulus grants, health care providers, including dentists, are eligible. Through the advocacy of the University of Medicine and Dentistry of New Jersey New Jersey Dental School, a provision was included in the bill that allows dental school clinics to receive Medicaid incentive funds if a dentist providing oral health services in a dental school clinic assigns his or her Medicaid payment to the clinic.

ADEA's agenda included informing Dr. Blumenthal about barriers facing dentists attempting to qualify for electronic health records (EHR) incentives, impediments to assignments of EHR

incentives, significant difficulties in applying the Meaningful Use Matrix for dentists and oral health services, and important considerations about the education and training of future dentists concerning health information technology.

From ADEA's perspective, the 45-minute conversation with Dr. Blumenthal was productive in that he came to better understand how steep the challenges are for practicing dentists and dental school clinics to qualify for Medicaid incentive funds. He responded positively when asked that representatives of oral health be involved more formally in the ongoing deliberations on this subject. He made several requests for information that ADEA is providing.

Representing ADEA was Mr. **Jack Bresch**, Associate Executive Director and Director of the ADEA Center for Public Policy and Advocacy (ADEA CPPA); Mr. **Joseph Lynch**, a partner in the law firm of King & Spalding, LLC and ADEA counsel; and Dr. **Elisabeth Kalendarian**, Assistant Dean for Clinical Affairs, Harvard School of Dental Medicine. Dr. Kalendarian also represented the Consortium for Oral Health Related Informatics (COHRI) and spoke to Dr. Blumenthal about the consortium's current HIT initiatives and its clinical research on oral health.

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In September, Dr. **Richard W. Valachovic**, ADEA Executive Director, Dr. **Christopher H. Fox**, Executive Director of the American Association for Dental Research (AADR) and Dr. **Robert Johns**, Executive Director of the National Dental Association (NDA) met with Dr. **Howard Koh**, Assistant Secretary for Health at the U.S. Department of Health and Human Services (HHS), and other HHS officials to discuss promoting oral health within HHS and the Obama Administration

The agenda of the 90-minute meeting included, among a variety of issues, the following:

- The value and importance of the Roundtable Discussion on Oral Health Disparities co-hosted by the HHS Office of Minority Health (OMH) and the National Dental Association (NDA) in August to raise the profile of oral health within HHS.
- The need for HHS to more vigorously pursue the recommendations of the 2000 Surgeon General's report, *Oral Health in America*.
- The importance of oral health with regard to the growing frequency of oral-systemic connections, including clinical recommendations offered in the recent Consensus Paper by the American Association for Periodontology (AAP) and the American College of Cardiology (AAC) for both medical and dental professionals to use in managing patients living with, or who are at risk for, either heart or periodontal disease. Dr. Koh stated that a recent Massachusetts Department of Public Health initiative aimed at informing Massachusetts residents emphasized that oral health is part of overall health.
- A brief description of some of the work being done in the field of salivary diagnostics and the expectation that public health officials could expect application of this science within 12-24 months for biomarkers associated with oral and pancreatic cancer. This would far exceed the NIH mandate of bringing salivary diagnostics to the field of public health by 2013.
- The devastating effects that result from a lack of access to dental care, particularly among minorities and that oral health can also be a significant problem in the armed forces, resulting in 30-35% of active or reserve troops being delayed or prohibited from deployment due to substandard oral health.

- The debate surrounding dental mid-level providers as a model that could help provide greater access to care for vulnerable populations highlights the dental community's need to reassess its current structure to deliver care to those in need.
- A description of the “Deamonte Driver Act” in the State of Maryland that delivers routine preventive dental care to those in need via a mobile van. The law was enacted as a result of the death of Deamonte Driver, a 12-year old Maryland boy, who died from an abscess in his mouth that went untreated. Dr. Koh noted that he is familiar with access to care issues since his time as Commissioner of the Massachusetts Department of Public Health, having overseen a commission on oral health during that time.

Others attending the meeting were Dr. **Garth Graham**, Deputy Assistant Secretary for Minority Health; Dr. **Rochelle Rollins**, Director, OMH Division of Policy and Data; Dr. **Conan Davis**, Chief Dental Officer, Centers for Medicare and Medicaid Services (CMS); Dr. **Christopher Halliday**, Assistant Surgeon General and Chief Dental Officer, Indian Health Service; Dr. **David Wong**, AADR President-elect, Associate Dean of Research, UCLA; and **Michael Kalutkiewicz**, AADR Director of Government Affairs.

Ryan White CARE Act to Continue Operating Through October 31

The Senate Health Education, Labor and Pensions (HELP) Committee passed the “Ryan White HIV/AIDS Treatment Extension Act of 2009,” a first step in ensuring eventual reauthorization of the program. Passage of the Continuing Resolution (CR) keeps the CARE Act in effect through October 31, 2009.

The HELP and Energy and Commerce committees crafted a bipartisan/bicameral bill supported by the AIDS community. This process created a compromise that will stabilize the Ryan White CARE Act program for the next four years while the expected health insurance reform legislation takes effect. Importantly, the dental provisions within the CARE Act are unchanged. ADEA is optimistic that both the House and Senate will move forward to ensure the passage of identical bills that could be signed into law by President Obama.

ADEA Members Advocate on Capitol Hill

Twenty-one members of the 2009 ADEA Leadership Institute completed Phase II of their yearlong program in September by attending an ADEA Legislative Workshop in which they heard presentations from “inside-the beltway” speakers and became skilled in issues of importance to oral health and dental education. The following day the Fellows conducted more than 50 meetings with their elected officials on Capitol Hill. The ADEA Leadership Institute develops faculty members from all elements of dental education as future leaders of dental and higher education.

The Fellows carried the following messages to Congress:

1. Include in the final version of health care reform oral health benefits for adults.
2. Retain in the final version of health care reform the following provisions that would address the challenges of educating and training an adequate dental workforce:
 - Reinstate dental as its own title in the Title VII Health Professions Programs under the Public Health Services Act;
 - Expand eligibility to dental schools for three federal grant programs under Title VII for which only medical schools are eligible; and
 - Create a new loan repayment program for dental school faculty.

3. Include in the final version of health care reform provisions that would:

- Allow the time medical and dental residents spend in didactic training activities to be eligible for GME funding.

House Passes Student Loan Legislation

On September 17, the House of Representatives passed the “Student Aid and Fiscal Responsibility Act of 2009” (H.R. 3221). This legislation would end the Federal Family Education Loan (FFEL) program. If the legislation is enacted, effective July 1, 2010, all new federal student loans will be originated through the Direct Loan (DL) program. The FFEL program utilized private student lenders. The Direct Loan program provides funds borrowed directly from the federal government. The Congressional Budget Office reported that the switch from FFEL to the DL program would save \$87 billion over ten years.

Additionally, the bill would authorize \$40 billion for the Pell Grant program. Maximum annual scholarship amounts would be increased to \$5,550 in 2010 and to \$6,900 by 2019. Starting in 2011, scholarships will match increases in costs-of-living by indexing them to the Consumer Price Index plus 1 percent. Pell Grants do not have to be repaid and are usually given to undergraduate students who do not yet have bachelor's degrees. *Students attending undergraduate schools of dental hygiene would benefit from this program.*

The House-passed bill would also make changes to the Perkins Loan program, which is a campus-based program that provides low-cost federal loans to students. The bill would change funding mechanisms of the program from private lenders to the federal government and would expand the program to include more schools. *This program is open to dental students.* It allows professional students to borrow up to \$30,000 over the course of their studies, minus any Perkins loans taken out in undergraduate school.

The legislation has not yet been considered by the Senate.

Kids’ Dental Benefits and GME Provision in Senate Finance Health Reform Bill

On September 16, Chairman of the Senate Finance Committee Max Baucus (D-MT) released his version of health care reform legislation. The bill includes a provision that requires any insurance plan that participates in an insurance exchange (created by the Baucus bill) to include dental benefits for children.

The Baucus bill also includes a provision clarifying that hospitals can receive both direct and indirect GME funding for medical and dental residents not only for the time they spend providing patient care services but also for the time they spend on patient-care related activities, such as educational seminars, classroom lectures, research conferences, patient-care related research as part of the residency program, and presentations of papers and research results to fellow residents, dental students, and faculty (didactic training). The Centers for Medicare and Medicaid Services (CMS) currently allows a hospital to receive Direct Graduate Medical Education (D-GME) funding for didactic training in a hospital setting, but neither D-GME nor Indirect Medical Education (IME) fund didactic training in a non-hospital setting. The American Dental Education Association has been seeking this clarification for years. When the Centers for Medicare and Medicaid Services turned a deaf ear to our advocacy, we approached Senator Baucus for relief. ADEA is grateful that the Chairman included this provision in his reform legislation.

The Senate Finance Committee is scheduled to vote on the measure on Tuesday, October 13. Few, if any, Republicans are expected to support the Baucus bill.

Stimulus Funding

Department of Health and Human Services (HHS) Secretary **Kathleen Sebelius** announced the availability of \$200 million to support grants, loans, loan repayment, and scholarships to expand the training of health care professionals. The funds are expected to train approximately 8,000 students and credentialed health professionals by the end of fiscal year 2010. Under the American Recovery and Reinvestment Act (ARRA, P.L. 111-5), a total of \$500 million was allotted to HHS to address workforce shortages. The other \$300 million was allocated to the National Health Service Corps. In addition, the Health Resources and Services Administration (HRSA) received \$2 billion through ARRA to expand health care services to low-income and uninsured individuals through its community health center program.

The funding is directed as follows:

- \$80.2 million for scholarships, loans, and loan repayment awards; of those funds
- \$47.6 million for the primary care and dental training programs
- \$50 million in grants to health professions training programs for equipment
- \$10.2 million to increase health professions diversity
- \$10.5 million to strengthen the public health workforce
- \$1.5 million to support the efforts of state professional licensing boards in reducing barriers to telemedicine

HRSA has posted on its website additional details about the \$200 million designated for health professions training under ARRA. According to the site, HRSA will offer new ARRA-supported competition for training in the Primary Care Medicine and Dentistry program, Preventive Medicine and Dental Public Health program, and telemedicine licensure portability special initiative, as well as grants to training programs for equipment. The remainder of ARRA grants was awarded to qualified 2008 applications. Additional information is available at <http://bhpr.hrsa.gov/recovery>.

The Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH) spending plans for Recovery Act funds are now available. AHRQ received \$300 million in ARRA funds, and will use the money to expand upon pre-existing CER activities and its Effective Health Care Program. NIH received \$400 million in ARRA funds and will use the money to "generate evidence through research," as well fund training and data infrastructure, dissemination, and translation.

Congressional Committee Calls for Office of Oral Health at HRSA

In the report accompanying the FY 2010 Labor-HHS-Education Appropriations legislation (H.R. 3293), the House Committee stated it was pleased that the Health Resources and Services Administration (HRSA) had appointed a Chief Dental Officer, **Jay R. Anderson**, D.M.D., M.H.S.A., in 2007. Additionally, it urged HRSA to establish an Office of Oral Health. The Office, which would be headed by HRSA's chief dental officer, would seek to rebuild the dental regional workforce and provide leadership and oversight of HRSA dental programs.

Governors Encourage States to Prepare for Electronic Health Records Adoption

A National Governors Association (NGA) alliance has issued a guide to help states implement the federal HITECH Act, which expands the role of states in fostering health information exchange and adoption of electronic health records (EHR) over the next five years. "Governors understand that swift and thoughtful action is needed at the state level to plan and implement a national system of health information exchange," Tennessee Governor **Philip N. Bredesen**, co-chair of the NGA's State Alliance for e-Health, said. "Widespread adoption and use of electronic health records provide a critical foundation for improving health outcomes and cost-effectiveness." Among other actions, *Preparing to Implement HITECH* recommends that states prepare or update their plans for adopting health information exchange and establish offices to

manage its implementation; engage health care providers and other stakeholders in planning efforts; implement privacy and security strategies and reforms; determine an HIE business model; and establish opportunities for health information technology training and education.

FDA Releases Final Rule on Safety of Dental Amalgam

In August, the Food and Drug Administration (FDA) issued its final rule on dental amalgam. The rule classifies dental amalgam as a class II device, reclassifies dental mercury from a class I to a class II device, and combines these two devices with amalgam alloy (which was already a class II device) under one regulation.

Class II devices are those that have “special controls” to ensure safety and effectiveness in addition to the “general controls” established for Class I devices. These special controls include performance standards, post-market surveillance, labeling requirements, and development and dissemination of guidelines and recommendations.

The special controls that the FDA is implementing for dental amalgam, dental mercury, and amalgam alloy are contained in a guidance document, which makes recommendations on performance testing, device composition, and labeling statements. The guidance document can be found at

www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm073330.pdf.

To read the final rule, please visit <http://edocket.access.gpo.gov/2009/pdf/E9-18447.pdf>.

Funding Opportunities Update

www.GRANTS.gov

You must use www.GRANTS.gov to apply for a federal grant. The registration process can take up to one month. Assistance is available from www.Grants.gov help desk at support@grants.gov or 800-518-4726. To successfully register, it is necessary to do all of the following:

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with Central Contractor Registry (CCR)
- Identify the organization's E-Business Point of Contact (POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register an Authorized Organization Representative (AOR)

National Institutes of Health

- **NIDCR Dentist Scientist Pathway to Independence Award (K99/R00)**, (PAR-09-256), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-256.html>
- **Oral Mucosal Vaccination against HIV Infection (R01)**, (RFA-DE-10-001), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-DE-10-001.html>
- **Exploratory Innovations in Biomedical Computational Science and Technology (R21)**, (PAR-09-219), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-219.html>
- **Dynamics of Host-Associated Microbial Communities (R01)**, (RFA-GM-11-001), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-GM-11-001.html>
- **Epigenetic Processes in Development (R21)**, (RFA-HD-09-033), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-HD-09-033.html>

- **NIGMS National Centers for Systems Biology (P50)**, (PAR-09-258), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-258.html>
- **Genetic and Genomic Analysis of Xenopus (R01)**, (PAR-09-240), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-240.html>
- **Genetic and Genomic Analysis of Xenopus (R03)**, (PAR-09-242), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-242.html>
- **Genetic and Genomic Analysis of Xenopus (R21)**, (PAR-09-241), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-241.html>
- **Early Detection Research Network: Data Management and Coordinating Center and Statistics and Biomarker Resource Center (U24)**, (RFA-CA-09-020), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-09-020.html>
- **Limited Competition: Addressing Health Disparities in Maternal and Child Health through Community-Based Participatory Research (R03)**, (RFA-HD-09-010), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-HD-09-010.html>
- **Consortia for High-Throughput-Enabled Structural Biology Partnerships (U01)**, (RFA-GM-10-007), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-GM-10-007.html>
- **Exfoliated Cells and Circulating DNA in Cancer Detection and Diagnosis (R21)**, (PA-09-238), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-09-238.html>
- **Mechanisms, Models, Measurement, and Management in Pain Research (R01)**, (PA-10-006), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-HG-09-014.html>
- **Mechanisms, Models, Measurement, and Management in Pain Research (R21)**, (PA-10-007), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-10-007.html>
- **Mechanisms, Models, Measurement, and Management in Pain Research (R03)**, (PA-10-008), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-10-008.html>
- **Community Networks Program (CNP) Centers for Reducing Cancer Disparities through Outreach, Research and Training (U54)**, (RFA-CA-09-032), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-09-032.html>
- **Bioengineering Nanotechnology Initiative (SBIR [R43/44])**, (PA-09-267), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-09-267.html>
- **Bioengineering Nanotechnology Initiative (STTR [R41/R42])**, (PA-09-266), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PA-09-266.html>

- **Specialized Programs of Research Excellence (SPOREs) in Human Cancer for Years 2010, 2011 and 2012 (P50)**, (PAR-10-003), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-10-003.html>
- **NIH Blueprint for Neuroscience Research Competitive Revisions for Studies Focused on Neuropathic Pain or Neural Plasticity to Promote Collaborative Pain Research (R01)**, (PAR-09-264), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-264.html>
- **Recovery Act Limited Competition: Building Sustainable Community-Linked Infrastructure to Enable Health Science Research (RC4)**, (RFA-OD-09-010), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-09-010.html>
- **Exceptional, Unconventional Research Enabling Knowledge Acceleration (EUREKA) (R01)**, (RFA-GM-10-009), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-GM-10-009.html>
- **Increasing the Service Life of Dental Resin Composites (R21)**, (RFA-DE-10-005), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-DE-10-005.html>
- **Increasing the Service Life of Dental Resin Composites (R01)**, (RFA-DE-10-004), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-DE-10-004.html>
- **Limited Competition for Research Centers in Minority Institutions Infrastructure for Clinical and Translational Research (RCTR) [U54]**, (PAR-09-261), National Institutes of Health, <http://grants.nih.gov/grants/guide/pa-files/PAR-09-261.html>
- **Institutional Clinical and Translational Science Award (U54)**, (RFA-RM-09-019), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-09-019.html>
- **2010 NIH Directors New Innovator Award Program (DP2)**, (RFA-RM-09-011), National Institutes of Health, <http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-09-011.html>

Agency for Health Care Research and Quality

- **AHRQ Small Grant Program for Conference Support (R13)**, (PA-09-231), and **AHRQ Grant Program for Large or Recurring Conferences (R13)**, (PAR-09-257), will fund conferences that advance quality, safety, efficiency, and effectiveness of health care. Conferences can focus on defining issues or challenges in the practice and delivery of health care; bringing faculty and students together with other stakeholders to develop or share information on products, curricula, or training competencies; and other topics. For more information, please visit <http://grants.nih.gov/grants/guide/pa-files/PA-09-231.html> and <http://grants.nih.gov/grants/guide/pa-files/PAR-09-257.html>, respectively.

Resources, Recent Reports, and Items of Note

- **State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain**, a Government Accountability Office Report to Congressional Requesters, examined the strategies that states use to monitor and improve access to dental for children in the Medicaid program. Almost all the states described initiatives to

improve access; however, barriers remain. The report can be found at www.gao.gov/new.items/d09723.pdf.

- **Dental Coverage in CHIP.** The Center for Medicaid and State Operations at the Center for Medicare and Medicaid Services (CMS) released its letter to state health officials that provided guidance on how to implement the dental benefit provisions and dental-only supplemental coverage that was passed in Section 501 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). To read the guidance in its entirety, please visit www.cms.hhs.gov/smdl/downloads/SHO100709.pdf.
- **NIH Grants Funded by the American Recovery and Reinvestment Act of 2009.** The National Institutes of Health has created a website that lists the grants that were funded by the American Recovery and Reinvestment Act of 2009 (ARRA), also known as the “economic stimulus bill.” The grants are sorted by state. The website is <http://report.nih.gov/recovery/arragrants.cfm>.

Quotable

“There is nothing more difficult to manage,
more dubious to accomplish,
nor more doubtful of success...
than to initiate a new order of things.

The reformer has enemies in all those who profit from the old order
and only lukewarm defenders in all those who would profit from the new order.”

Niccolò di Bernardo dei Machiavelli
The Prince

The ADEA Washington *Update* is published by the ADEA Center for Public Policy and Advocacy (ADEA CPPA) monthly when Congress is in session. Its purpose is to keep ADEA members abreast of federal issues and events of interest to the academic dental and research communities.

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FY 2010 FEDERAL BUDGET

HRSA – TITLE VII HEALTH PROFESSIONS PROGRAMS

	Final FY07	Final FY08	Final FY09	FY2010 House	FY2010 Senate Comm.
Total Title VII Programs	\$184.74 m	\$193 m	\$221.69 m	\$266.30 m	\$243.35 m
Total Primary Care Medicine/Dentistry	\$48.85 m	\$48 m	\$48.4 m	\$56.4 m	\$54.4 m
General & Pediatric Dentistry	\$10 m	\$10.3 m	\$10 m	\$10 m	\$15 m
Total Diversity/Student Assistance	\$64.4 m	\$69.7 m	\$86.8 m	\$100 m	\$93.8 m
Centers of Excellence	\$11.8 m	\$12.7 m	\$20.6 m	\$24.6 m	\$24.6 m
Health Careers Opportunity Program	\$3.9 m	\$9.8 m	\$19.1 m	\$22 m	\$22 m
Faculty Loan Repayment Program/Minority Faculty Fellowship Program	\$1.3 m	\$1.3 m	\$1.3 m	\$1.3 m	\$1.3 m
Scholarships for Disadvantaged Students	\$47.1 m	\$45.8 m	\$45.8 m	\$52.8 m	\$45.8 m
Area Health Education Centers	\$28.68 m	\$28.2 m	\$32.5 m	\$34 m	\$32 m
Health Education and Training Centers	\$0	\$0	\$0	\$0	0
Quentin Burdick Rural Training	\$0	\$0	\$0	\$0	0
Allied Health	\$3.96 m	\$8.8 m**	\$13.8^	\$23.8 m^^	\$15.8 m^^^
Geriatric Programs	\$31.54 m	\$30.1 m	\$30.9 m	\$41 m	\$31 m
Public Health, Preventive & Dental Public Health	\$7.92 m	\$8.3 m	\$9 m	\$9 m	\$10 m

HIV/AIDS BUREAU – RYAN WHITE CARE ACT (RWCA)

	Final FY07	Final FY08	Final FY09	FY2010 House	FY2010 Senate Comm.
Total RWCA	\$2.13 b	2.14 b	\$2.2 b	\$2.29 b	\$2.27 b
Dental Reimbursement Program and Community-based Dental Partnership Programs	\$13.08 m	\$12.9 m	\$13.4 m	\$13.7 m	\$13.4 m
AIDS Education and Training Centers	\$34.7 m	\$34.1 m	\$34.3 m	\$35 m	\$34.3 m

NATIONAL INSTITUTES OF HEALTH

	Final FY07	Final FY08	Final FY09	FY2010 House	FY2010 Senate Comm.
Total NIH	\$28.8 b	\$28.9 b	\$30.3 b	\$31.2 b	\$30.7 b
National Institute of Dental & Craniofacial Research	\$393 m	\$390 m	\$402.6 m	\$417 m	\$409 m
National Center for Minority Health & Health Disparities	\$198.3 m	\$200 m	\$205.9 m	\$213 m	\$209 m
Office of the Director	\$1.09 b	\$1.05 b	\$1.2 b	\$1.16 b	\$1.18 b

OTHER FEDERAL PROGRAMS OF INTEREST

	Final FY07	Final FY08	Final FY09	FY2010 House	FY2010 Senate Comm.
Dental Health Improvement Act	\$2 m	\$5 m	\$10 m	\$20 m	\$10 m
CDC Oral Health Programs	\$11.6 m	\$12.37 m	\$13 m	\$15 m	\$15 m
Indian Health Service Dental Programs	\$125.4 m	\$133.6 m	\$141 m	\$152 m	\$151 m
National Health Service Corps	\$125.5 m	\$123.5 m	\$134 m	\$141 m	142 m

**The increase in the Allied Health budget designates \$5 million for the Dental Health Improvement Act (DHIA), which had been funded under HRSA program management in fiscal years 2006 and 2007.

^The increase in the Allied Health budget designates \$10 million for the Dental Health Improvement Act (DHIA), which had been funded under HRSA program management in fiscal years 2006 and 2007.

^^ The increase in the Allied Health budget designates \$20 million for the Dental Health Improvement Act (DHIA), which had been funded under HRSA program management in fiscal years 2006 and 2007.

^^^ \$10 million of the Allied Health budget designates \$10 million for the Dental Health Improvement Act (DHIA).

***An additional \$11 million for dental recruitment is a separate line item and is not part of the total NHSC budget.

**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**

**U.S. House of Representatives
Committee on Oversight and Government Reform
Subcommittee on Domestic Policy**

October 7, 2009

My name is Dr. 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 serves 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

Surgeon General Dr. David Satcher'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 who 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 one third of the U.S. population to over one half (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 has 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 the underserved.

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 ethnically 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 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 FQHCs

Program Participants

2002-2007

Boston University
 University of Connecticut
 Howard University
 West Virginia University
 University of North Carolina at Chapel Hill
 Meharry Medical College
 University of Illinois at Chicago
 The Ohio State University
 University of Washington
 University of California, San Francisco
 The Maurice H. Kornberg School of Dentistry, Temple University
 University of California, Los Angeles
 University of the Pacific Arthur A. Dugoni School of Dentistry
 University of Southern California
 Loma Linda University

2008-2010

A.T. Still University of Health Sciences
 Creighton University
 Baylor College of Dentistry
 Medical College of Georgia Research Institute, Inc.
 University of Maryland
 University of Florida
 University of Medicine and Dentistry of New Jersey
 Virginia Commonwealth 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, and 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. The American Dental Education Association 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.

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