

ADA American Dental Association®

**STATEMENT OF THE
AMERICAN DENTAL ASSOCIATION**

TO THE

**SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES**

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

ON

**SUPPORT OF DENTAL AND ORAL HEALTH-RELATED PROGRAMS AT
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

SUBMITTED BY

**RONALD L. TANKERSLEY, D.D.S.
PRESIDENT**

**May 12, 2010
2:00-4:30 P.M.**

Summary

On behalf of the American Dental Association (ADA), President Ronald L. Tankersley, D.D.S., an Oral and Maxillofacial Surgeon from Newport News, VA will testify before the subcommittee on Labor, Health and Human Services, Education and Related Agencies on May 12 at 2 pm.

- The ADA supports the work of National Institute of Dental and Craniofacial Research (NIDCR) but also believes that more must be done to understand the social, behavioral and biological determinants of oral and dental diseases and their impact on dental care. Furthermore, while NIDCR's research has established a strong association between oral health and systemic health there is more to uncover. Therefore, the ADA recommends that the Committee fund the NIDCR at \$463 million to continue to advance its research agenda.
- The new "Training in General, Pediatric and Public Health Dentistry" health professions program calls for funding to support the development and operation of general practice, pediatric and public health dental residency training programs; provide educational assistance for students; enhance faculty development; and provide faculty loan repayment. The ADA recommends the Training in General, Pediatric and Public Health dentistry programs be funded at the authorized amount of \$30 million and that current appropriation levels for dental residencies be maintained.
- In 2008, the CDC's Division of Oral Health received 32 grant applications to help states build their dental departments. Unfortunately, the Division had only enough funding to support 16 states. The states that received grants have been able to plan, implement and evaluate a variety of oral health programs. The Division also has the authority to offer states and communities grants to establish or update community water fluoridation systems. The ADA recommends \$33 million to fully fund the Division's state infrastructure grant program and to help local communities establish or rebuild their community water fluoridation systems.
- The Maternal and Child Health Bureau has supported state and community health programs through grant funding that focus on improvements increasing the number of children receiving age one dental visits, expanding services to children with special health care needs, and increasing the number of children completing restorative treatment needs identified through sealant programs. The program currently only supports 20 states. The ADA recommends that this program be funded at \$8 million so that all 50 states can participate.

On behalf of the American Dental Association (ADA), which represents over 157,000 dentists, (more than 70 % of all dentists practicing in America) thank you, Mr. Chairman and members of the subcommittee for the opportunity to comment on FY 2011 appropriations for federal dental programs. I am Dr. Ronald Tankersley, a practicing oral surgeon and president of the ADA.

The ADA last testified before the Committee in 2006 advocating for federal programs that provide dental research and education, as well as oral health prevention and community-based access programs. Since that time, there have been many advances in oral health programs due in large part to the strong support provided by this committee. But there still remains much more to do to reduce oral disease and increase access to dental care.

Two questions often asked by Committee members are – how have federal dollars been used and what is the outcome of those expenditures? We will show in our testimony how the Committee's investment in federal dental programs directly impacts the delivery of dental care in America and improves the oral health of its citizens.

National Institute of Dental and Craniofacial Research

Since 2005, the National Institute of Dental and Craniofacial Research (NIDCR) has established three regional research networks relying on private practicing dentists to conduct clinical research to answer questions they face every day in treating their patients. To date, nearly 700 practitioner-investigators have enrolled over 30,000 patients in 16 studies. Study findings have improved clinical decision-making for treatment of early tooth decay, addressed post-operative sensitivity, how to choose the most appropriate dental materials and improved patient education. These networks are important as they allow for the rapid translation of scientific advances into clinical practice while generating much needed data to guide and evaluate the delivery of oral health care.

Salivary diagnostics continues to be an important research field for NIDCR. It is now believed that saliva can one day be used to diagnose breast, prostate, oral, and pancreatic cancer, as well as detecting cardiovascular disease, drug usage, and exposure to toxic molecules that may cause diseases like anthrax. Because saliva is easy to collect and poses none of the risks, fears, or “invasiveness” of blood tests or exposure to x-rays it holds a potential to be a remarkable cost and time-saver for patients. For example, NIDCR is currently supporting aggressive efforts to provide clinical validation of preliminary results that could result in a self-contained, portable diagnostic test for cardiovascular disease. In related work, salivary biomarkers are being evaluated to detect myocardial infarction in patients presenting with chest pain at emergency departments. Currently, patients believed to have suffered a heart attack are kept overnight so that blood can be drawn several times over a 24 hour period to determine if a heart attack has occurred.

NIDCR-funded investigators are also working as a consortium with more than 1,900 affected families from eight countries to find additional genes involved in the formation of cleft lips and palates. Their work will have considerable benefits internationally and domestically. According to the Centers for Disease Control and Prevention (CDC), in the United States, cleft lip and palate is the third most common birth defect. Health expenditures are approximately eight times higher in the first 10 years of life for children with these birth defects than for those without.

While the NIDCR has advanced the scientific understanding in these areas of dental research it is important to recognize that dental caries remains the most prolific communicable disease in the world and that early childhood caries is still epidemic in underserved populations. The ADA supports the work of NIDCR but also believes that more must be done to understand the social, behavioral and biological determinants of oral and dental diseases and their impact on dental care. Furthermore, while NIDCR's research has established a strong association between oral health and systemic health there is more to uncover. Therefore, the ADA recommends that the Committee fund the NIDCR at \$463 million to continue to advance its research agenda.

Training in General, Pediatric and Public Health Dentistry

Four years ago when we last testified before the committee, the Administration had proposed eliminating funding for the health professions' general practice and pediatric dental residencies. This committee not only restored the funding but as of this year has nearly doubled their appropriation. That support has stabilized and increased the number of general residency programs to 554 in 2009.

Pediatric dental residency positions increased by 131 between 2005-2009. However, according to CDC data, tooth decay is on the rise among young children for the first time in 40 years, so we need to continue to increase the supply of general and pediatric dentists who treat children. Furthermore, there are 3 states that have fewer than 10 pediatric dentists. North Dakota and Vermont have eight and Wyoming has six.

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), through a new authorization, calls for increasing the funding for these residency programs as well as fully funding public health dental residencies. Public health dentists are integral for monitoring the oral health status of communities; investigating public health problems; conducting epidemiologic and health services research; establishing and evaluating community-based prevention programs; developing policies to enhance and protect the public's oral health; educating and providing oral health information; mobilizing community partnerships; and assuring coordinated access for all Americans to appropriate prevention and treatment services.

Currently, there are only 180 board certified public health dentists in the country. As of last November, there are no dentists actively serving full-time within the Health Resources and Services Administration (HRSA) regional dental consultant billets. This prevents the agency from providing valuable full-time assistance to health centers. There are only 11 board certified public health dentists serving as state dental directors. Rebuilding the local, state and federal aspects of the dental public health infrastructure, which includes recruiting and retaining public health dentists, is key to implementing the prevention and wellness provisions of the PPACA.

The new "Training in General, Pediatric and Public Health Dentistry" health professions program also calls for funding to support the development and operation of dental training programs; provide educational assistance for students; enhance faculty development; and provide faculty loan repayment. Under the PPACA, academic dental institutions are now eligible for Predoctoral and Postdoctoral Training in Primary Care, Academic Administrative Units in Primary Care, and Faculty Development in Primary Care. The ADA recommends the Training

in General, Pediatric and Public Health dentistry programs be funded at the authorized amount of \$30 million and that current appropriation levels for dental residencies be maintained.

CDC's Division of Oral Health

The PPACA for the first time has provided vital funding for prevention and wellness programs. For oral health, the law calls for the CDC's Division of Oral Health to develop an oral health prevention education campaign, a research-based dental caries (tooth decay) disease management program, and a national dental sealant program, as well as updating national dental health studies. These provisions are especially important because of the increase in tooth decay and survey data that shows only one-third (33 percent) of mothers considered oral health a concern for their infants. Additional survey findings reported by the American Academy of Pediatric Dentistry found that just 14 percent of parents realized that tooth decay in children can ultimately lead to the need for a root canal – even in infants.

However, the data also revealed that oral health literacy campaigns can have a profound effect. 78 percent of the survey respondents agreed they would take their children to visit a pediatric dentist before their first birthday if they knew that the visit would result in better oral health as the children developed. Ensuring that parents receive such education can also result in cost savings. Studies show that dental costs for children who have their first dental visit before age one are 40 percent lower in the first five years than for those who do not see a dentist prior to their first birthday.

To address these concerns, the ADA has developed a National Health Literacy in Dentistry Action Plan. As part of that program, the ADA is developing an oral health literacy campaign that will educate the public, policy makers, dental professionals and other health care workers about the importance of good oral health. We believe that our efforts would be enhanced and more effective if CDC and other federal agencies could join with us in a public-private partnership.

To carry out these new and expanded prevention programs the CDC's Division of Oral Health will need to rely on state dental programs. In 2008, the CDC received 32 grant applications to help states build their dental departments. Unfortunately, the Division had only enough funding to support 16 states. The states that received grants have been able to plan, implement and evaluate a variety of oral health programs. For example, Arkansas increased its fluoridation rate from 49% to 64%, formed a state oral health coalition with 38 member organizations, instituted an oral health literacy program and funded a state-developed oral disease burden document identifying oral health disparities and unmet needs.

One of the easiest and most cost effective ways to reduce dental disease is through community water fluoridation, which has proven to be safe and effective in reducing dental decay in both children and adults by 30–50%. At a savings of about \$23–\$26 per person per year, this translates to national annual savings in dental treatment costs of more than \$4 billion per year. Currently, 27 states have met the national objective of having at least 75% of their population on public water systems receive optimally fluoridated water. The CDC Division of Oral Health is authorized to provide grants to communities to purchase water fluoridation equipment which would be used to increase the number of states that provide fluoridated water to 75% of their

citizens and support states that need to replace their aging equipment. More than 30 states have identified communities that need equipment upgrades. Other states, such as Louisiana, have unfunded mandates to fluoridate water systems. In Louisiana alone, additional funding for fluoridation equipment could extend fluoridation to more than 2 million people. The ADA recommends \$33 million to fully fund the Division's state infrastructure grant program and to help local communities establish or rebuild their community water fluoridation systems.

State Oral Health Workforce Program

Funding for state dental workforce grants has grown from \$2 million in 2005 to \$17.5 million today due to the Committee's support. This program has been highly popular and successful because it allows states flexibility to use funds in a variety of ways to increase access to oral health care in a manner that best matches their needs. As of 2009, over 25 states had received grants. Funding has been used to offer loan forgiveness to dental providers who practice in underserved areas, establish or expand dental facilities, set up mobile clinics, support dental residency programs, and establish teledentistry programs for distance-based dental education, among other projects. The ADA recommends that \$20 million funding be appropriated for this program.

Maternal and Child Health Oral Health SPRANS Program

Since 2003, the Committee has supported state and community oral health programs in the Maternal and Child Health Bureau (MCHB). State oral health programs have used the funding to better integrate oral health into state MCH programs and address MCHB performance measures to the benefit of women and children. The current grant program supports 20 States in building capacity to expand preventive and restorative oral health service programs for Medicaid and State Children's Health Insurance Program (SCHIP) eligible children, and other underserved children and their families. States specifically focus on improvements within one or more of the following three program areas:

- increasing the number of children receiving age one dental visits,
- expanding services to children with special health care needs, and
- increasing the number of children completing restorative treatment needs identified through sealant programs

The program is currently funded at \$3.2 million which allows each participating state a grant of approximately \$165,000. The ADA recommends that this program be funded at \$8 million so that all 50 states can participate

Patient Protection and Affordable Care Act

Mr. Chairman, the ADA was profoundly disappointed that the PPACA did not address improving dental coverage for children and adults eligible for Medicaid. In addition, while the PPACA calls for increasing Medicaid payments to physicians there is no such provision for dentists.

Data show that there is a direct relationship between the level of reimbursement and dentists' participation in Medicaid and the utilization of services by beneficiaries. Michigan's Healthy Kids Dental (HKD) program dramatically improved access in selected rural communities through a partnership between the state, the Michigan Dental Association and Delta Dental. Dentists in those counties are paid at Delta PPO rates. Under this program the participation of

dentists in Medicaid went from 20 percent to 90 percent. Over 2,000 additional dentists joined the program. The distance between providers was cut in half – making it easier for patients to access care. The typical dentist in the program added over 50 Medicaid-enrolled patients to his/her practice. The ADA believes that Medicaid programs like Michigan’s HKD program should be expanded into both rural and urban areas.

We were very disappointed that the PPACA did not support this approach because as of 2007, the Centers for Medicare and Medicaid Services (CMS) reported that only 34 percent of the total eligible Medicaid population received dental care with less than 2 percent of the entire Medicaid expenditures going for dental care.

We fear that the situation is only going to get worse. Of the 50 states and the District of Columbia, only nine have what could fairly be called full dental Medicaid coverage for adults. Eighteen have what we consider a limited benefit package. Sixteen cover only emergencies. And eight states have no adult benefits at all. Michigan and Utah have recently eliminated adult services, and California curtailed its adult program to cover only pregnant women.

Furthermore, because the PPACA extends Medicaid eligibility to individuals in families with incomes up to 133 percent of the federal poverty level without addressing the funding issue, and without providing a basic adult dental benefit for existing or new Medicaid enrollees, Congress is essentially promising an insurance card without real access to oral health care.

Consequently, because the PPACA did not address improving access to dental care under Medicaid, the programs we discussed today under this Committee’s jurisdiction become even more important for preventing oral disease and improving access to dental care. Therefore, we strongly urge the Committee to support our funding recommendations.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to address the Committee. I would be glad to answer any questions you might have.