Written Comments on Draft National Oral Health Plan

Call to Action

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by the
American Academy of Pediatric Dentistry

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Summary of AAPD Recommendations

• There is a pressing need for the “National Plan” to identify and help fund effective public-private models that will increase Medicaid reimbursement and program efficiency.

• The AAPD’s analysis of the Michigan Healthy Kids Dental Program, which involves a partnership between the state government and Delta Dental Insurance, indicates this should be promoted in the “National Plan” as a model program for other states.

• The significant shortage of pediatric dentists is a pressing public health and public policy concern that should be addressed in the “National Plan.”

• The AAPD Foundation’s public education campaign, a significant public-private partnership, should be promoted via public service messages from the “National Plan.”
What is the role of the American Academy of Pediatric Dentistry?

Our members are the “front line” providers of oral health care to America’s children.

The American Academy of Pediatric Dentistry (AAPD) is the membership organization representing the specialty of pediatric dentistry. Our 4,800 members serve as primary care providers for millions of children from infancy through adolescence; provide advanced, specialty-level care for infants, children, adolescents, and patients with special health care needs in private offices, clinics, and hospital settings; and are the primary contributors to professional education programs and scholarly works concerning dental care for children.

Individuals trained in Pediatric Dentistry learn advanced, diagnostic, and surgical procedures; child psychology and clinical management; oral pathology; pharmacology related to the child; radiology; child development; management of oral-facial trauma; caring for patients with special health care needs; conscious sedation; and general anesthesia. Since children’s oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists.

Our members push the envelope of science, and transfer it into practice

The AAPD emphasizes a three part approach to advancing the oral health care of children. In the area of Clinical Practice, AAPD members not only provide an extensive scope of preventive and treatment services for children in a wide variety of clinical settings, but are also the pre-eminent body for establishing guidelines and policies that define professional norms for oral health care for children. The AAPD’s Reference Manual is widely recognized as the authoritative source in this regard. With respect to Teaching, AAPD members are responsible for educating future pediatric dentists, provide the bulk of instruction on dental care for children for other dental specialists and general dentists, and establish the educational standards for pre-doctoral and post-doctoral dental education programs. Finally, in the area of Research, AAPD members conduct a broad range of studies in laboratories and clinical settings to advance the oral health of children and contribute extensively to the scientific literature on related topics. Together, the three elements of the AAPD work for the benefit of all children.
The AAPD is the recognized authority on pediatric oral health care

The AAPD, representing over 95% of all pediatric dentists, is the clearly recognized leader in several prominent areas, including:

- The development of pediatric dentistry clinical policies and practice guidelines, including periodicity schedules;
- The dissemination of consumer information about pediatric oral health care through our web site, media efforts, and various publications; and
- Advocacy for improved pediatric oral health care.

The AAPD works in partnership with general dentists and pediatricians

The AAPD offers an affiliate membership category for general dentists and non-dental health care providers interested in oral health care for children, and works closely with other dental, medical and child advocacy organizations.

The American Academy of Pediatrics (AAP) recognizes the contributions of AAPD members by maintaining an AAP associate membership category for pediatric dentists.

The AAPD is a partner on several key federal initiatives

The AAPD played a major role in the development of the U.S. Department of Health and Human Services “Bright Futures” oral health guidelines, and also recently developed a revised Medicaid EPSDT Dental Manual under contract with the Centers for Medicare and Medicaid Services. Currently the AAPD is carrying out two federal grants: completing the final year of a four year $375,000 CHIP Partnership Grant funded by the Health Resources and Services Administration’s Maternal and Child Health Bureau (MCHB) to develop and disseminate “best practices” in oral health care programs aimed at pre-school children; and beginning a five year $500,000 Partners in Program Planning for Adolescent Health grant (also funded by MCHB) that will develop oral health messages aimed at adolescents. Finally, we support a pediatric dental consultant in each of the ten federal regions to assist regional federal teams working with states to improve dental Medicaid programs.
What is the Oral Health Status of America’s Children?
We Have Not Conquered the Disease Yet

As thoroughly documented in the 2000 U.S. Surgeon General’s Report, “Oral Health in America,” although the oral health of our nation’s children has improved dramatically over the past three decades, large pockets of children with severe dental disease and disability continue to exist in our country. Children of families with low incomes suffer more than twice the rate of tooth decay than children in middle and upper income families.\(^1\) As highlighted in the *Journal of the American Medical Association*, “tooth decay is the most common chronic disease of childhood.”\(^2\) It is five times more common than asthma. Eighteen percent of 2-4 year olds have visually evident caries, and by ages 6-8, 52 percent of U.S. children have already experienced tooth decay. It is, in the words of the Surgeon General, “a silent epidemic.”

The Surgeon General reported that 80 percent of all dental disease occurs in only 25 percent of all children. These children, who represent approximately 20 to 25 percent of all U.S. children, are more likely to live in low income and/or minority families, and not only have increased dental disease but more extensive disease and more treatment for pain. Low income, low education, and minority status are all associated with lower odds of having dental visits.\(^3\) An estimated four to five million children are in acute dental need. The profound disparities in oral health were also discussed in the U.S. General Accounting Office’s April 2000 Report “Dental Disease is a Chronic Problem Among Low-Income Populations.”

Good oral health is inextricably linked to a child’s overall health and well being. Poor oral health is linked to slower growth rate for toddlers and poor nutrition in children. Afflicted children experience pain and infection, and are distracted from learning. Each year, children spend over 1.1 million days sick in bed and nearly 500,000 miss school days because of an acute dental condition. Children suffering from untreated dental decay may be subject to other complicating medical conditions, as

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\(^1\) The Third National Health and Nutrition Examination Survey (NHANES III) showed that dental decay is experienced by 30 percent of children 2-5 years old and 40 percent of children 6-12 years old from families with incomes below 100 percent of the federal poverty level.


well as inadequate diet and hygiene. Poor dental health in children is frequently a marker for poor overall health.

Children who do not receive regular dental check-ups often end up seeking expensive hospital emergency room care. One-third of all children seeking emergency care for toothaches have abscessed teeth. For many of these children, the emergency room is their first trip to the “dentist.” This is unfortunate, as a study of Louisiana’s dental Medicaid system found that reducing early childhood caries through early intervention could provide substantial costs savings as compared to hospitalization (an estimated $104 per patient compared to $1,508 ). A study of the Texas Medicaid Dental program found that the reimbursement amount for patients admitted to the hospital (for episodic, non-definitive care) was ten times greater than the anticipated amount for preventive care.4

**What can be done in a National Oral Health Plan?**

The AAPD will focus our comments on solutions we strongly believe will work. The problem is well understood and innovative solutions are needed. The time for reports and meetings has passed: action is needed!

Our testimony will focus on two goals of the draft National Oral Health Plan: removing known barriers between people and oral health services, and using public-private partnerships to improve the oral health of those who suffer disproportionately from the disease.

**National Plan Proposal:**

**Remove known barriers between people and oral health services**

*The plan suggests addressing the lack of dental insurance, public and private, the low level of reimbursement for oral health services, and development of integrated and comprehensive care programs for persons with physical, mental, or emotional impairments.*

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AAPD Recommendation 1: To improve pediatric oral health services for low-income families, the Medicaid dental program must be reformed.

It is not a mystery why the problem exists. Medicaid dental programs have been poorly funded and poorly operated for some time. Only in the past few years have we seen some signs of positive reform.

While it is encouraging that the majority of U.S. children already have ready access to oral health services financed through commercial plans or family funds, the Surgeon General’s Report indicated that almost three times as many children lack dental insurance as lack medical insurance. There is also a huge disparity in oral health funding between private and public insurance plans. Private plans commit 23 percent of their health care dollars toward dental care, while public plans commit only 2.3 percent. This same sort of experience is not seen with access to medical care. Children with Medicaid coverage and children with private insurance are fairly similar in their use of medical services. However, a 1996 report from Department of Health and Human Services Office of the Inspector General found that only one in five Medicaid eligible children receive any dental services annually, while four in five Medicaid eligible children receive medical services. This occurs even though dental care is a mandatory covered service for children under Medicaid!

Indeed, a recent study in our journal found disproportionate little spending on low-income and minority children in Medicaid dental programs, and surprisingly high levels of out-of-pocket expenditures given that Medicaid prohibits cost-sharing. Fully 40 cents of every dollar expended on dental care for poor children was paid out of pocket!5

Thus, many improvements must be made in Medicaid dental programs. Some of the necessary steps are highlighted in a September 2000 General Accounting Office Report (“Factors Contributing to Low Use of Dental Services by Low-Income Populations”).

AAPD Recommendation 2: The federal government should continue to support the January 18, 2001 letter to State Medicaid Directors by the Director of the Center for Medicaid and State Operations at CMS (formerly HCFA).

This CMS directive focuses on improving access in states with oral health care Medicaid patient utilization below 30 percent.

**AAPD Recommendation 3:** CMS should establish a permanent Chief Dental Officer position so that oral health expertise and oversight in the agency will continue.

This is especially significant in providing planning and technical support for CMS to spur innovative reforms at the state level, and effectively oversee the Medicaid dental program.

**AAPD Recommendation 4:** The federal government should support incentive grants to states to promote effective Medicaid Dental programs.

This could be accomplished under innovative legislation currently before the U.S. Congress, S. 1626 and H.R. 3659, the Children’s Dental Health Improvement Act of 2002. This would not impose a mandate on states, but rather serve as a stimulus for helping to improve access to dental care – providing states flexibility within their Medicaid and SCHIP programs and incentives to initiate reforms. It would greatly assist efforts in many states by supporting the movement toward market-based Medicaid dental reform, matching providers with underserved populations, and reaching the many children who do not have dental coverage although they have medical coverage and are therefore ineligible for SCHIP.

One specific provision in this legislation we highlight is Medicaid performance grants to those states that improve delivery of dental services and provide adequate payment. Under this $50 million authorization, state eligibility would require assurances of efforts for improved service delivery (including outreach, case management), adequate payment rates (at market-based rates), and ensuring that access is available to the same extent as the general population.

Federal agencies should communicate to Congress, when asked, how important this authority would be to accomplish a national oral health plan that works. This legislation, by the way, has been endorsed by over 40 national dental and medical organizations.
AAPD Recommendation 5: The federal government should support innovative state efforts such as the Michigan Healthy Kids Dental Program.

The Michigan Health Kids Dental (HKD) Program has shown great progress toward providing access to comprehensive care and overcoming chronic problems that have discouraged dentists’ participation in Medicaid. It also validates the Academy’s long-standing position that if the Medicaid dental program can be fixed, many of the access issues will be solved. This should be a much higher priority than “band-aid” approaches such as increasing dental chairs in community health centers, or training physicians to spot dental decay and refer for treatment.6

The AAPD conducted a November 2001 site visit of this program as part of our “Filling Gaps” HRSA MCHB CHIP partnership grant described earlier. The Healthy Kids Dental program was initially launched in 22 counties and has been expanded to 37 counties, with plans for further expansion to at least 80 of Michigan’s 83 counties. Area dentists have responded positively to two notable program features: administration of the plan by Delta Dental of Michigan and reimbursement rates that pay 100% of dentists’ charges up to plan limits (approximately the 75th percentile of area fees).

Data obtained from state Medicaid officials indicate that utilization of services nearly doubled, from 18% to 34% of eligible children, during the first eight months of the program. This represents a 78.7% increase. Recently released 12-month data further show that the new program has closed 50% of the “gap” between utilization of dental services by Medicaid children and those covered by Delta commercial plans. The number of area dentists participating in Medicaid increased 43% (from 556 to 806) in the first 8 months of the program, providing greater geographic access to services. Service profiles suggest that enrolled children initially are getting more services overall and more restorative services than children in traditional Medicaid and Delta commercial programs.

6 While the AAPD has been at the forefront of better educating pediatricians on oral health, through our partnership with the AAP, it is misguided to suggest that a dental “exam” can be accomplished during a physical exam by a provider who is not trained to do this. Studies indicate a low level of understanding of oral diseases among primary care physicians. While increasing this knowledge base is important, it is not a substitute for direct dental care and workforce needs. At best, a primary care physician may serve as a useful screener and referrer for oral health care. Physicians cannot restore teeth and are not equipped to perform thorough dental diagnoses.
However, preliminary data also suggest that once their initial treatment needs are met, Healthy Kids Dental children are returning for maintenance care and their treatment costs are dropping to levels comparable to commercially insured children once their initial treatment needs have been met.

The State achieved this through its contract with Delta Dental who offered its entire network of providers to HKD eligible patients. In essence, the State purchased a provider network.

Dentists are reporting much higher levels of satisfaction with HKD in terms of increased reimbursement, claims processing and overall program operation.

Beneficiaries are reporting higher satisfaction rate with HKD than traditional Medicaid in terms of the overall program, finding a dentist that will accept their child, traveling less distance to get to a dentist, and improving their child’s overall health and the quality of treatment received.

Michigan has made tremendous progress towards improving access to and utilization of dental services among low-income children. The preliminary evidence indicates that the Michigan “model” should be closely explored for development in other states. Central to the success of Michigan’s HKD program is the fact that it uses a commercially administered plan with benefit and reimbursement levels widely accepted by a majority of the state’s dentists.

AAPD Recommendation 6: Remove barriers to providers by increasing the number of Pediatric Dentists.

Children with more advanced disease are more likely to require the services of a specialist in pediatric dentistry. There are only an estimated 3,800 practicing pediatric dentists in the U.S. Although limited in numbers and unevenly distributed, pediatric dentists provide approximately 30 percent of oral health care services for children in the U.S., and treat a disproportionate percentage of Medicaid, SCHIP, medically compromised, and disabled children. Pediatric dentists tend to provide more complete and less sporadic care to the Medicaid population, and are especially successful with this population because of their advanced clinical training and expertise in behavior management.
Pediatric dentistry training is critical to meeting the nation’s oral health care needs, and it has become abundantly clear that the U.S. is not training enough pediatric dentists to meet the increasing need for pediatric oral health care services. Because of increased attention to this problem, there has been a thirty percent increase in first year positions over the past seven years, but this is just a small dent in the overall need. Furthermore, 47 percent of all applicants to pediatric dentistry training positions for 2002-2003 were turned away due to a lack of positions. Some training programs have 25 times the number of applicants that can be accommodated.

The decreased number of available pediatric dentists is adversely impacting both private practice and academics. Pediatric dentists are needed not only to treat children but also to train general dentists to provide pediatric services. Many positions for pediatric dentists remain open in private practice, public health clinics, dental schools, residency training programs, corporate employment, and government service. We must increase the number of practicing pediatric dentists dramatically in order to have any hope of improving the oral health status of underserved children.

The authority to fund Pediatric Dentistry Residency training under HRSA health professions programs (Title VII) was enacted under the Health Professions Education Partnerships Act of 1998. This expanded the existing General Dentistry training authority, providing three year “start up” funds to either increase Pediatric Dentistry positions at existing programs or initiate new programs. Title VII support from the HRSA Bureau of Health Professions is critical to expanding this training in the future. In the first 2 years of funding, FY 2000 and FY 2001, a total of approximately $2.7 million in grants were provided to 14 institutions. However, there were 11 approved but un-funded pediatric dentistry programs in these two years. Providing $15 million for the Primary Care Pediatric and General Dentistry Training program for FY 2002 would meet this training need and improve the nation’s pediatric oral health care. This request is supported by not only the AAPD, but also the American Dental Association, the American Dental Education Association, and the Children’s Dental Health Project. However, the Administration’s FY 2003 budget proposal again recommends elimination of this program, ignoring evidence of its effectiveness. The National plan must clearly address this issue.

The plan should also support expansion of the HRSA MCHB Centers for Leadership in Pediatric Dentistry Education, which are responsible for developing leading educators and researchers in our field.
National Plan Proposal:

*Use public private partnerships to improve oral health of those who disproportionately suffer oral diseases.*

The plan suggests building and nurturing broad-based coalitions, and developing partnerships that are community-based, cross-disciplinary, and culturally competent.

AAPD Recommendation 7: The federal government should support the AAPD Foundation’s public education campaign aimed at primary care providers and children’s families.

As noted, the AAPD is the key dental organization in partnership with the American Academy of Pediatrics (AAP), our medical counter-part. This spring there will be a joint AAPD-AAP mailing to all active U.S. pediatrician members of the AAP containing a poster on oral health targeted to families. This poster was developed under our Foundation’s Public Education Campaign “Good Health Starts Here.” Pediatricians will be asked to display this poster in their offices.

The AAPD Foundation’s *Good Health Starts Here* campaign, to be launched this year, will target caregivers, adolescents and other health care professionals that serve children 1) to educate them that oral health is an essential component of general health, and 2) to promote methods these groups can perform on themselves or children under their care to prevent oral disease and maintain health. This information will be conveyed to these audiences through a series of age-specific messages on key oral health topics. Messages will be delivered to these groups through several strategic mechanisms including, but not limited to, collateral materials distributed at pediatricians’ offices, placement on childcare product labels, and through a national media campaign.

We are excited about this campaign, and would welcome a partnership with the federal government in disseminating these messages, through vehicles such as public service announcements. Major corporate supporters of this campaign include Procter and Gamble. This is an ideal type of public-private partnership.
Conclusion

The AAPD thanks you for the opportunity to comment on the proposed national oral health plan, and for taking strong steps towards eliminating disparities in our children’s oral health.