REQUEST: A key focus of any health care reform legislation that moves forward should be to establish a dental home for every child, maintain dental insurance as separate coverage from medical insurance, and target coverage priority to those children most in need by improving Medicaid dental programs. Specific provisions of critical importance to children’s oral health should be addressed as follows:

- Retain children’s oral health coverage as part of any essential benefits package.
- Require oral health expertise on any health benefits advisory committee or similar body.
- Per the Senate bill, clarify that separate/stand-alone dental insurance for children may continue to be offered under any insurance exchange.

- Expanding coverage for children under Medicaid but not fixing underlying problems with Medicaid dental programs is a recipe for disaster. Add provisions for Medicaid dental reform, either to increase fees to the 75th percentile of prevailing rates (ADA regional fee survey), or increase Medicaid matching payments for states that pursue specific Medicaid dental reforms including reimbursement at competitive market-based rates (per H.R. 2220).
- Retain workforce provisions to reauthorize Title VII dental training programs under a separate funding line and allow the Title VII Pediatric Dentistry program to expand authority for pre-doctoral curriculum development, faculty development, and especially loan repayment for pediatric dental faculty. Language from the Senate bill is preferred. However, dental hygiene training should be deleted from these primary care training program funds, because hygienists cannot provide comprehensive oral health care or provide a dental home for a child.
- Exclude dental expenses from any proposed excise taxes on health savings accounts and insurance plans. Such provisions would cause many families with current dental coverage to lose it.
- Clarify that pediatric dental procedures are not subject to any cosmetic procedures tax, and that dental devices are not subject to any device tax. Such provisions would merely increase the cost of providing pediatric dental services.
- Delete provisions for alternative dental provider demonstration projects, which are a diversion of $60 million in resources that do not provide a dental home for children.

BACKGROUND: The tragic February 2007 death of 12-year-old Maryland child Deamonte Driver from a tooth infection which spread to his brain prompted several legislative proposals to improve children’s access to oral health care. Many in Congress rightfully felt this should never have happened in our country, and one important step was to reauthorize the Children’s Health Insurance program (CHIP) with critical dental provisions. As signed into law on February 4, 2009, the CHIP reauthorization provides for a guaranteed dental benefit for children, and also requires that oral health education materials be provided to pregnant women. The law also requires enhanced data collection on dental services actually provided to CHIP children, and clarifies that federally qualified health centers may contract with private dentists for services. In addition, the law provides for a “dental wrap” so that states may, at their option, provide CHIP eligible children with a dental benefit if they already receive medical coverage through their parent. Congress should be applauded for this action.

Yet there are other initiatives that are needed to improve children’s access to oral health care. There is strong evidence of Medicaid dental program reforms that work, based on experiences from several states as summarized in the chart below presented by Dr. James J. Crall in 2008 testimony before the Domestic Policy Subcommittee of the House Oversight Committee. Dr. Crall also serves as Child Advocate for the AAPD.

<table>
<thead>
<tr>
<th>STATE</th>
<th>Adjustment to Medicaid Rates (Market Benchmarks)</th>
<th>Changes in Dentists’ Medicaid Participation</th>
<th>Intervals After Rate Increases (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>85% of each dentist’s submitted charges</td>
<td>1 private dentist to 130 (of 378 licensed dentists)</td>
<td>48</td>
</tr>
<tr>
<td>Indiana</td>
<td>75th percentile</td>
<td>+58%</td>
<td>54</td>
</tr>
<tr>
<td>Michigan</td>
<td>Healthy Kids Dental</td>
<td>100% of Delta Dental PPO (61 of 83 counties)</td>
<td>+300%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>75th percentile</td>
<td>+73%</td>
<td>36</td>
</tr>
<tr>
<td>Tennessee</td>
<td>75th percentile</td>
<td>+81%</td>
<td>42</td>
</tr>
</tbody>
</table>

AAPD and the American Dental Association are currently preparing updated analysis of Medicaid dental reforms that work, building upon the above information.
On April 30, 2009, Congressman Mike Ross (D-4th AR) and Congressman Mike Simpson (R-2nd ID) introduced H.R. 2220, the Essential Oral Health Care Act of 2009. The bill would increase federal Medicaid matching funds (federal medical assistance percentage, or FMAP) by 25 percent for those states that meet the following criteria:

- Children enrolled in the State plan have access to oral health care services to the same extent as such services are available to the pediatric population of the State.
- Payment for dental services for children under the State plan is made at levels consistent with the market-based rates.
- No fewer than 35 percent of the practicing dentists (including a reasonable mix of general dentists, pediatric dentists, and oral and maxillofacial surgeons) in the State participate (whether directly or through a plan providing dental services) under the State plan and there is reasonable distribution of such dentists serving the covered population.
- Administrative barriers are addressed to facilitate such provider participation, including improving eligibility verification, ensuring that any licensed dentist may participate in a publicly funded plan without also having to participate in any other plan, simplifying claims forms processing, assigning a single plan administrator for the dental program, and employing case managers to reduce the number of missed appointments.

**JUSTIFICATION:** All of the recommendations above address the major barriers to oral health care access to children by promoting insurance coverage for children from low-income families and necessary funding for Medicaid dental programs to achieve adequate dentist participation. They also keep oral health care reform from veering off into unintended consequences such as reducing current coverage or diverting resources to misguided schemes. They do support and augment the training of the front-line pediatric dentists and general dentists who provide a dental home for children.

(Footnotes)

1 The term “dental home” refers to an ongoing relationship between a dentist and patient, inclusive of all aspects of oral health care delivery in a comprehensive, continuously accessible, coordinated and family-centered way. The AAPD and other professional organizations involved in children’s oral health recommend that a dental home be established by no later than 12 months of age and include referrals to dental specialists when appropriate.

2 CHIP plans must provide a dental benefit, which is defined as “coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.” States may elect to meet this requirement through any of three “benchmark plans”: (1) most frequently chosen federal employee dependent dental coverage; (2) most frequently chosen state employee dependent dental coverage; or (3) commercial coverage (“A dental benefits plan that has the largest insured commercial, non-Medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.”)