Hearing of the United States Senate Committee on Finance, Subcommittee on Health: An Oral Health Crisis: Identifying and Addressing Health Disparities

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Chairman Cardin, Ranking Member Daines and Members of the Subcommittee:

My name is Warren A. Brill, DMD and I am a private practice dentist in the state of Maryland and also represent the American Academy of Pediatric Dentistry, serving as their congressional liaison to engage federal policymakers on policies affecting pediatric dentistry. I have practiced pediatric dentistry for 45-years, providing care to children in Baltimore city and surrounding counties. I fully understand the oral health disparities too many children and parents face – whether they be racial, cultural, due to disability, economic, geographic or a combination of several of these disparities. I thank you for holding this important hearing today.

I would like to share with you the story of one of my Medicaid patients who is a constant inspiration for me, named Dawn. I first started treating Dawn when she was 13. Dawn has challenging physical and intellectual disabilities. She did not communicate and was extremely shy. Dawn came to me with badly decayed front teeth that needed extraction and extreme pain with her back teeth. After receiving dental treatment, Dawn communicated more openly, improved and grew her relationships, and was able to better function at school and work. When Dawn turned 21, she aged out of Medicaid dental coverage, as the state of Maryland like many other states went many years without covering adult dental benefits.[1] She struggled to find care in the absence of having health insurance at the time, and I decided to keep her in my practice as a pro bono patient.

Our collective experience – yours and mine – with our oral health care likely looks very different than Dawn's. This means we have a responsibility to do more and to do better. While there are many actions we can and should take to improve the dental Medicaid benefit, I recommend this Subcommittee start with three key actions to better support our Nation's children, particularly those served by Medicaid and CHIP:

- **First**, take steps to ensure every child has a dental home no later than age 1.
- **Second**, make sure no child who has significant oral disease and needs dental surgery suffers in pain or risks the spread of infection due to lack of hospital access or extensive surgical backlogs; and
- **Third**, consider options for utilizing tax incentives to expand the dental workforce to support rural and other underserved communities.

[1] Effective January 1, 2023, dental services are available to all adults over the age of 21 who receive full Medicaid benefits in the state of Maryland.

Establishing a Dental Home

While we have seen the prevalence of tooth decay nationally decrease in the U.S., nearly one-in-five children under the age of five has experienced dental decay. Dental decay IS NOT an equal opportunity disease. Children living in poverty are twice as likely to suffer tooth decay and two-times as likely to go untreated as compared to more affluent peers. This disparity is also prominent in the disability community. We know that tooth decay compromises the health, development, and quality of life of children, affecting such factors as eating, sleeping, self-esteem, speech development and school performance.

The American Academy of Pediatric Dentistry (AAPD) and other dental and medical professional groups endorse the importance of having the child's first visit dental visit on or before age one to establish a dental home. The Academy defines a dental home as an ongoing relationship between the dentist and a patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.[2] A dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute and comprehensive oral health care and includes referrals to dental specialists when appropriate. Early dental visits can prevent suffering from dental pain and/or disease, reduce dollars spent on future surgical and emergency dental services, and maximize the chances for children to grow up with healthy, happy smiles. Medicaid's Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefits for children help to increase access to important dental services for children.

Young children are more vulnerable to oral disease and its consequences given that they depend on others to receive care. We also know that children living in poverty have a higher risk of dental decay.[3] Non-Hispanic black and Hispanic children are almost three times more likely to live in poverty than white children. Dental caries (decay) prevalence varies with family income. In 2014–2015, 52 percent of children and youth aged 2–19 from families living below the federal poverty level had any dental caries experience, compared to 34 percent of children from families with income levels greater than 300 percent of the federal poverty level.[4]

We have an epidemic of dental caries in many of our youngest children. Poor diet and low overall health literacy affect these disparities. Dentists observe children with diets high in sugar and without the benefit of early preventive care, contributing to early childhood caries.

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[2] American Academy of Pediatric Dentistry. Definition of dental home. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2022:15.
[3] Vargas CM, Ronzio CR. Disparities in Early Childhood Caries. BMC Oral Health 2006;6(Suppl 1):S3. Available at: "http://www.biomedcentral.com/1472-6831/6/S1/S3". Accessed March 27, 2023.
[4] Fleming E, Afful J. Prevalence of Total and Untreated Dental Caries Among Youth: United States, 2015-2016. NCHS Data Brief 2018;(307):1-8.

Disparities in dental disease exist based on race and ethnicity as well. Among children and youth aged 2–19 years, the prevalence of total dental caries was highest for Hispanic youth (52 percent) compared with black (44 percent), Asian (43 percent), and white youth (39 percent). The prevalence of untreated dental caries was highest among black children (17 percent) compared with Hispanic (14 percent), white (12 percent), and Asian children (11 percent). [5] Often times, children seen in the emergency room for dental pain attributed to decay are predominantly minority children from low-income families.[6]

To address these disparities and support a dental home for all children, Congress must ensure that Medicaid EPSDT advances efforts to promote the dental home concept.

The Academy also strongly supports efforts that have been led by Chairman Cardin through S. 570, the *Medicaid Dental Benefits Act of 2023* to ensure dental care is covered across state Medicaid programs for adults. When parents have access to dental benefits and receive needed dental care, their children are more likely to also be established with a dental provider.[7]

The Academy also is concerned about the many challenges patients with disabilities who are covered by Medicaid experience as they transition out of Medicaid as children, and they seek care, particularly if the state does not provide an adult dental Medicaid benefit. Far too often, pediatric dentists struggle to find a dentist to provide ongoing care when a patient ages out, as addressed in the example I provided today.

The Academy also wishes to highlight additional provisions within S. 570 that would support continued dentist participation in the Medicaid program to support young children and adult parents alike, including Medicaid audit reform for dentists. Audits are necessary to identify improper payment and instances of fraud within Medicaid programs. Unfortunately, the quality and consistency of auditing practices vary greatly between contractors and by state. Although audits are a critical part of maintaining program integrity, they are most effective when they can make a clear distinction between truly fraudulent practices and honest mistakes and can be conducted by professional peers familiar with dentistry. Auditing practices failing to make this distinction threaten to have a substantial impact on children's access to oral health care through a reduction in the number of pediatric dentists willing to participate in Medicaid. Nearly 70 percent of pediatric dentists participate in the Medicaid program today, and support for audit reform is sorely needed to ensure dentists continue to participate.

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[5] Ibid.
[6] Hill BJ, Meyer BD, Baker SD, et al. State of Little Teeth Report. 2nd ed. Chicago, IL: Pediatric Oral Health Research and Policy Center, American Academy of Pediatric Dentistry; 2019.
[7] Lipton BJ, Finlayson TL, Decker SL, Manski RJ, Yang M. The Association Between Medicaid Adult Dental Coverage and Children's Oral Health. Health Aff (Millwood). 2021 Nov.

Support Operating Room Access for Dental Surgery

Given the complex health care needs of some of patients I have described and the need for dental rehabilitation surgery under general anesthesia, the most optimal care setting for these surgeries is in an operating room.

The Academy has witnessed a major decrease in operating room access for dental procedures over the last decade. The Academy conducted surveys of the pediatric dental community,[8] finding that in a majority of states, operating room access for pediatric dentists is a persistent problem, and in most states – particularly rural states – it can be a severe problem, given fewer access sites and longer scheduling delays. Pediatric dentists report that COVID-19 made things far worse as hospitals have had to halt elective procedures and then face immense backlogs of medical and dental cases. Too often, pediatric and other dentists have seen dental cases fall to the very back of the line in terms of hospital prioritization as medical procedures are first addressed. In most states this access problem, which predominantly impacts people with disabilities, has worsened even as the worst of the COVID-19 pandemic subsided. Dental patient wait times for operating room access can be six months to a year or even longer.[9] For dental patients who await treatment, pain management, antibiotics, and temporary band aid-like approaches to management are the only option, but not a fair or equitable one. Change is needed to ensure that children and adults with disabilities and chronic health conditions are not forced to unnecessarily wait to receive treatment in a safe setting that can fully meet their needs.

The dental community attributed this operating room access challenge to the lack of a sustainable billing mechanism for dental surgical services in both Medicare and Medicaid. While the dental services that are needed are already covered services, the facility services to provide care in the operating room are not separately recognized or valued for what they include: expertise on staff to address emergencies, anesthesia, equipment, medication, recovery observation and support, and infection control. The bottom line is that dental rehabilitation surgical services for children and adults with complex dental needs, until recently, did not have a specific Medicare billing code or fair associated reimbursement when these services are provided in a hospital. There is also no billing mechanism today to allow for additional operating room sites, such as ambulatory surgical centers (ASCs), to support and expand access capacity particularly in rural and other underserved community. The lack of a viable billing mechanism in Medicare also directly impacts the Medicaid program as the majority of state Medicaid programs look to Medicare billing codes and payment policy as a benchmark for determining Medicaid billing codes and payment rates for surgical services.

[8] Denial of Access to Operating Room Time in Hospitals for Pediatric Dental Care. AAPD. May 2021. Available at https://www.aapd.org/globalassets/media/advocacy/ord.pdf.
[9] Ibid.

I am pleased to inform the Subcommittee that the Academy worked with the broader dental and disability communities to begin addressing this problem with CMS. Following a final Medicare hospital outpatient rule issued last year,[10] beginning in January 2023, CMS established an improved Medicare billing and payment system to support hospital expenses for dental surgeries, issuing a new billing (CPT) code and associating that code with an ambulatory payment classification (APC) focused on the cost of dental surgical services.[11] These important reforms should allow for more equitable consideration of dental cases in hospitals going forward. Dentists are recommending that state Medicaid programs also adopt the billing and payment changes CMS established for hospitals, which is a decision up to each individual state Medicaid program.

We must now address disparities for people in rural and other underserved communities who travel long distances to receive hospital-based care or where their hospitals are still over capacity and unable to accept additional operating room cases. The most viable option is for CMS to permit ASCs to provide dental surgeries. We have asked CMS to move forward this year to allow dental surgeries to be covered and fairly reimbursed in ASCs. In last year's final OPPS rule, CMS stated that it would consider this issue for future rulemaking.[12] I want to thank Chairman Cardin and Senator Blackburn for working together this year to engage CMS in support of this effort. I encourage all Subcommittee members to help and encourage CMS to include the new dental rehabilitation surgery Medicare code on the ASC Medicare Covered Procedures List this year for implementation in January 2024.

Consider How Tax Incentives Can Support and Expand the Dentist Workforce

To address geographic disparities, we must talk about enhancing the dental workforce. Dentistry has long advocated for loan repayment and forgiveness options, but these are simply not enough. The average student loan debt for a dentist is roughly $300,000.[13] As faculty salaries are significantly less than private practice opportunities, there is a disincentive to enter academia.

Congress established and the Health Resources and Services Administration (HRSA) administers the Dental Faculty Loan Repayment Program (DFLRP). The program may support loan repayment contracts over five years to recruit and retain faculty. Full-time faculty members are eligible for repayment of 10, 15, 20, 25 and 30 percent of their student loan balance (principal and interest) for each year of service while providing dentistry in an underserved community. The program is making an impact in the recruitment of promising new pediatric dentistry faculty, but more help is needed to retain additional pediatric dental faculty to support

[10] 87 FR 71748 (Nov. 23, 2022).
[11] CMS established CPT G0330 (dental rehabilitative surgery) and associates the code with APC 5871 for dental procedures.
[12] Ibid.
[13] Dentists of Tomorrow 2022. American Dental Education Association. September 2022. Available at https://www.adea.org/Seniors2022/.

expansion of the pediatric dentist workforce. Unless the tax code is amended, individual recipients of DFLRP must pay income tax on their awards.

The Academy encourages the Subcommittee to consider options to strengthen loan repayment support through tax reform policies. As a start, to support the DFLRP, Congress could exclude the amount of loan forgiveness received from federal income taxes.

The Academy recognizes Chairman Cardin for working with the dental community on creative tax policies like this and introducing bipartisan legislation in prior Congresses to address tax concerns with the DFLRP specifically, and we encourage additional efforts to explore tax benefits to grow the dental workforce.

Conclusion

I thank you again for the opportunity to testify as a private practice pediatric dentist and on behalf of the American Academy of Pediatric Dentistry. I hope that today is the beginning of an active dialogue this congressional session to develop policies, advance needed legislation, and implement regulatory reforms that can address the oral health disparities faced by too many people in our country.