S. HRG. 118–505

AN ORAL HEALTH CRISIS: IDENTIFYING AND ADDRESSING HEALTH DISPARITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

MARCH 29, 2023

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

57–588—PDF WASHINGTON : 2025

COMMITTEE ON FINANCE

RON WYDEN, Oregon, *Chairman*

DEBBIE STABENOW, Michigan	MIKE CRAPO, Idaho
MARIA CANTWELL, Washington	CHUCK GRASSLEY, Iowa
ROBERT MENENDEZ, New Jersey	JOHN CORNYN, Texas
THOMAS R. CARPER, Delaware	JOHN THUNE, South Dakota
BENJAMIN L. CARDIN, Maryland	TIM SCOTT, South Carolina
SHERROD BROWN, Ohio	BILL CASSIDY, Louisiana
MICHAEL F. BENNET, Colorado	JAMES LANKFORD, Oklahoma
ROBERT P. CASEY, JR., Pennsylvania	STEVE DAINES, Montana
MARK R. WARNER, Virginia	TODD YOUNG, Indiana
SHELDON WHITEHOUSE, Rhode Island	JOHN BARRASSO, Wyoming
MAGGIE HASSAN, New Hampshire	RON JOHNSON, Wisconsin
CATHERINE CORTEZ MASTO, Nevada	THOM TILLIS, North Carolina
ELIZABETH WARREN, Massachusetts	MARSHA BLACKBURN, Tennessee

JOSHUA SHEINKMAN, *Staff Director*
GREGG RICHARD, *Republican Staff Director*

SUBCOMMITTEE ON HEALTH CARE

BENJAMIN L. CARDIN, Maryland, *Chairman*

RON WYDEN, Oregon	STEVE DAINES, Montana
DEBBIE STABENOW, Michigan	CHUCK GRASSLEY, Iowa
ROBERT MENENDEZ, New Jersey	JOHN THUNE, South Dakota
THOMAS R. CARPER, Delaware	TIM SCOTT, South Carolina
ROBERT P. CASEY, JR., Pennsylvania	BILL CASSIDY, Louisiana
MARK R. WARNER, Virginia	JAMES LANKFORD, Oklahoma
SHELDON WHITEHOUSE, Rhode Island	TODD YOUNG, Indiana
MAGGIE HASSAN, New Hampshire	JOHN BARRASSO, Wyoming
CATHERINE CORTEZ MASTO, Nevada	RON JOHNSON, Wisconsin
ELIZABETH WARREN, Massachusetts	MARSHA BLACKBURN, Tennessee

CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

AN ORAL HEALTH CRISIS: IDENTIFYING AND ADDRESSING HEALTH DISPARITIES

WEDNESDAY, MARCH 29, 2023

U.S. SENATE,
SUBCOMMITTEE ON HEALTH CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:30 p.m., in Room SD–215, Dirksen Senate Office Building, Hon. Benjamin L. Cardin (chairman of the subcommittee) presiding.

Present: Senators Wyden, Stabenow, Warren, and Daines.

Also present: Democratic staff: Martha P. Cramer, Staff Director and Health Policy Advisor for Senator Cardin; and Carolyn A. Perlmutter, Legislative Correspondent for Senator Cardin. Republican staff: Grace Bruno, Health Policy Advisor for Senator Daines; and Matthew May, Legislative Correspondent for Senator Daines.

OPENING STATEMENT OF HON. BENJAMIN L. CARDIN, A U.S. SENATOR FROM MARYLAND, CHAIRMAN, SUBCOMMITTEE ON HEALTH CARE, COMMITTEE ON FINANCE

Senator CARDIN. The subcommittee will come to order.

Let me welcome everyone to the first meeting of the Subcommittee on Health Care of the Senate Finance Committee of this Congress. I want to thank Senator Wyden and Senator Crapo for their cooperation in the establishment of the subcommittee and our ability to hold hearings. And, Senator Daines, I want to thank you for your help and cooperation. I look forward to working with you.

We have, obviously, a very important agenda, and I hope that the subcommittee will be able to do some oversight as to some of the issues that are pretty pressing in our health-care system, during this Congress. I look forward to working with you, and I am very pleased that Senator Stabenow is here.

Senator Stabenow has been one of the great leaders on health care in the U.S. Senate, and she served with great distinction as chair of this subcommittee. So I thank her for her help, and I know of no subject that she has been more active in than on oral health care. She has been one of our great leaders in the area of oral health care.

So, today's subject is the oral health crisis, the need to address disparities. Disparities in our health-care system are well documented, and the impact they have in regard to vulnerable communities. With the passage of the Affordable Care Act, we elevated the Institute for Minority Health and Health Disparities as a full institute under the National Institutes of Health, NIH.

They have documented the disparities based upon income. Lower-income communities do not have the same health-care providers in their community as we see in other communities. They have documented it in rural America, where again there are not as many health-care providers. They have documented disparities based upon race and ethnicity, because again, there are not as many providers in regards to the workforce.

So, we have documented a lot of the reasons for disparities in our health-care system, and they are very prevalent, the disparities as they relate to oral health care.

It really came home to me when I was first elected to the United States Senate in 2007. Many have heard me talk about Deamonte Driver, but I am going to mention him one more time. Deamonte Driver was a 12-year-old who lived in Prince George's County, MD, about 7 miles from here. He had a tooth problem. His mom tried to get him help but could not find a dentist to take care of his needs.

She tried several times and was unable to get any help. She fell through the cracks. She was not in the Medicaid system at the time, and there were some eligibility issues, but she did not have any reimbursement.

Deamonte ultimately became very sick, was rushed to the hospital. He had an impacted tooth, went through two operations, and what would initially have cost $80 for a tooth extraction ended up costing hundreds of thousands of dollars, and tragically Deamonte Driver lost his life.

So that really struck home, that a person in my community that I represented, that we could have that type of an outcome. Now it has led to some changes in health-care policy. Working with Senator Stabenow, working with my dear friend Elijah Cummings in the House, we were able to extend pediatric dental under both the CHIP program and the Affordable Care Act.

So we were able to make some progress, but there are still many gaps today. Oral health is integral to overall health and well-being. It can make worse an underlying health condition, an impact affecting overall health-care costs. It can impact a person's ability to get a job and be well enough to work. It impacts a person's ability to go to school, affecting the local and national economy. It can impact a person's confidence and ability to enjoy life or communicate effectively, affecting communities and overall society.

Despite the importance of oral health, millions of people in the United States are not getting the care that they need. Former U.S. Surgeon General David Satcher said more than 20 years ago that you cannot be healthy without oral health.

Certainly, we have made progress in improving oral health for children since then, especially for vulnerable children. But for working-age adults and seniors, disparities in oral health outcomes and access to dental care have widened by income and race. Treating dental care as an essential in U.S. health policy for all ages, not just children, is the only way that we can address these disparities.

The oral health crisis is costly, and taxpayers are paying for it through worse outcomes for people with diabetes or heart disease, worse pregnancy outcomes, and through emergency room visits. We

are paying more in our health-care system as a result of these disparities. One study found that the U.S. could save over $22 billion annually by improving oral health care.

This is not a partisan issue. During the Trump administration, the U.S. Surgeon General and NIH began working on a report that became "Oral Health in America: Advances and Challenges," which was released by the Biden administration in 2021. This was a follow-up to the landmark report of 2000, "Oral Health in America: Report of the Surgeon General," which provided a comprehensive look at the importance of oral health and the disparities in the United States.

I have been pleased to work with the Biden administration to advance a number of oral health priorities, including the historic appointment of Dr. Natalia Chalmers to be the Centers for Medicare and Medicaid Services' Chief Dental Officer. That position lay vacant for many years. We finally got it filled, and we are very pleased that we have that position, in order to put a focus within HHS on oral health care.

And at the beginning of this year, Maryland Medicaid began covering adults. However, 16 percent of Maryland residents are over 65 years of age, and approximately 626,000 people in my State and more than 70 percent of the seniors in Maryland do not have dental health insurance. We have gaps that we need to deal with.

To echo the former U.S. Surgeon General, C. Everett Koop, "there is no health without oral health." Adequate access to oral health care is essential to preventing tragedies like the passing of Deamonte Driver. I hope we can work together to try to narrow the disparity gaps that we have and find ways that we can deal with the health-care crisis.

With that, let me turn it over to my distinguished ranking member, Senator Daines.

[The prepared statement of Senator Cardin appears in the appendix.]

OPENING STATEMENT OF HON. STEVE DAINES, A U.S. SENATOR FROM MONTANA

Senator DAINES. Chairman Cardin, thank you. Thanks too for sharing that very personal story as well. It kind of paints the reality of what is happening today in our country. I am really glad to be with you, hosting our very first subcommittee hearing of this Congress.

It is also nice we have a Montanan here, Mr. Jon Forte from RiverStone Health in Billings, where my dad graduated from high school as well. We will have a more formal introduction shortly, but thanks for being here, Jon. Glad you could join us.

Oral health care is really important. It is crucial, both for its own sake and in relation to our overall health and well-being. As I told my staff, when you have a toothache, nothing else really matters at that point.

A number of conditions can be associated with oral health implications, including diabetes, cardiovascular disease, arthritis, and Alzheimer's. There are also studies indicating links between mental health and oral health, and some of the first signs of mental health stressors can actually manifest in the mouth. As we continue to

look for holistic approaches to caring for the mind as well as the body, oral health has a distinctive role to play.

Over the years, there has been much bipartisan success in providing access to dental health care, such as through the Children's Health Insurance Program and Medicare Advantage. I am proud of these accomplishments and what these programs have achieved, but as we all will hear today and know, there are challenges to be addressed. When we consider disparities in access to oral health care, perhaps the greatest barrier for Montanans and Americans in rural States is geography.

In Montana, oftentimes we have to travel great distances to receive any kind of health care, especially to see a dentist or a dental specialist. In part, this is because of how large Montana and the West are, but also because of significant shortages we are experiencing in the health-care workforce, shortages which are disproportionately felt in more rural areas of our country.

Just earlier this month, I sat down with members of the Montana Dental Association, and their number one concern was workforce, subsequently followed by housing and housing costs. Housing is a top issue for their staff members and dental care teams. One provider shared that he had never heard his team talk so much about affording a place to live. This is in Montana.

Another concern is the mental health of our dental community. We are all aware of the mental health crisis in our country, and of course our health-care professionals are not immune from experiencing this crisis themselves, especially in Montana where suicide is sadly taking far too many lives.

Like physicians, the dental profession is linked to high levels of stress, depression, anxiety, and burnout. Dentists can have, additionally, distinct challenges as both providers and then also having to run a small business.

The COVID pandemic exacerbated these struggles, contributing to the workforce shortages we are experiencing today. As we move beyond the pandemic, it is my priority to ensure that our dental providers and all who serve in our health-care workforce have the resources they need to care for their mental wellness.

The number of community health centers that offer dental services, by the way, has grown by 60 percent in the last 10 years, and in Montana we are forced to have 93 percent of our health-care centers offering dental services on site. Our community health centers are a critical part of the solution that we need going forward.

I am grateful for all the work our health centers do to provide access to dental care and address disparities throughout Montana and the country. I want to acknowledge here Chairman Cardin's longtime leadership on this particular area of health care, and also thank the witnesses for being here today and bringing your expertise to this very important subject. I look forward to the discussion.

Mr. Chairman, thank you.

[The prepared statement of Senator Daines appears in the appendix.]

Senator CARDIN. Well, Senator Daines, thank you for your comments. I just really want to underscore the importance of our community health centers in providing dental care, and I appreciate

you mentioning that in Montana. I am sure it is true also in Michigan, and it is clearly true in Maryland.

I have visited many of our community health centers that a decade ago were not providing dental services that are doing it today, and it really is providing a great deal more coverage. In our community health centers, we are seeing not just children; we are also seeing the adult population. So it has really been a major step forward. So, thank you for mentioning that. I appreciate it very much.

We have four distinguished witnesses that we are going to hear from. Let me first introduce Dr. Warren Brill from Maryland, a dentist and owner of the Eastpoint Pediatric Dental Associates—and I must acknowledge, a friend and advisor.

Dr. Brill has been practicing pediatric dentistry for over 45 years and operates a full-time practice in Baltimore, primarily serving Baltimore City and Baltimore County. However, a sizeable number of his patients travel over an hour to receive care from his office or through surgical services he provides at the University of Maryland Rehabilitation and Orthopaedic Institute. Approximately 80 percent of his patient base is Medicaid-eligible.

He is also a clinical associate professor of pediatric dentistry at the University of Maryland. Dr. Brill serves as chairman of the Oral Health Advisory Committee to the Secretary of Health and Mental Hygiene for the State of Maryland. He is a consultant for pediatric oral medical devices for the FDA. He is past president of the American Academy of Pediatric Dentistry.

What do you do in your spare time? [Laughter.]

For our next introduction, I will yield to the ranking member for Mr. Forte.

Senator DAINES. Mr. Chairman, thank you. I am happy to introduce Jonathan Forte—what a great last name, Forte—this afternoon. Jon joined RiverStone Health in Billings, MT as president and CEO on January 3, 2023. We are glad you are in Montana and leading this critically important facility and operation.

RiverStone Health provides public health services to Yellowstone County, offers primary care, dental, and behavioral health at eight locations in Billings, Worden, Bridger, and Joliet. He also owns the Eastern Montana Area Health Education Center and the Montana Family Medicine Residency. We all know that is a really important part of the equation on health care: training the next generation of health-care professionals for Montana.

Jon spent the first decade of his leadership career serving veterans in various management roles throughout the VHA administration, and is board-certified in health-care management and as an American College of Healthcare Executives fellow.

Jon is an avid skier, a backpacker, paddle boarder, and a beekeeper. His true passion is teaching adaptive skiing and coaching individuals with disabilities to live an active life. Jon and his wife Liz, a certified nurse midwife—when do you have time to get out and ski and paddle board?—have three daughters and currently reside in Billings, MT.

Jon, welcome.

Senator CARDIN. You left out the most important part of his background. He served on the Eastern Shore of Maryland.

Senator DAINES. We stole him from you, Senator Cardin. I did not want to tell you that.

Senator CARDIN. Our third witness is Cherae Farmer-Dixon, dean and professor of Meharry Medical College School of Dentistry, an HBCU located in Nashville, TN. Dr. Farmer-Dixon has overcome barriers in race and gender in becoming the third woman to head the School of Dentistry at Meharry Medical College. She remains one of the few select women to lead in the role as a dean of a dental program that produces 27 percent of our Nation's currently practicing African American dentists. Dr. Farmer-Dixon has served in the dental school for 32 years.

Prior to assuming the role of dean, she was the associate dean of academic and student affairs in the School of Dentistry. Dr. Farmer-Dixon has also dedicated 20 years of service to her country as a lieutenant colonel in the United States Army Reserves. Thank you for your service to our country. We really appreciate that. She is a native of Mississippi, and we are pleased to have you with us today. Welcome.

Our final witness will be Dr. Marko Vujicic, who currently serves as chief economist and vice president of the Health Policy Institute at the American Dental Association. In this role, he oversees a comprehensive research program focusing on the U.S. dental care system.

Dr. Vujicic has published extensively in peer review journals such as *Health Affairs* and *The New England Journal of Medicine.* He is also the lead author of the book "Working Is Health," which examines health workforce challenges globally, and has written several book chapters on health-care policy issues.

He received his Ph.D. in economics from the University of British Columbia. Welcome. It is wonderful to have you here.

We will start with Dr. Brill. Your full statements will be made part of our record. You may proceed as you wish.

STATEMENT OF WARREN BRILL, DMD, OWNER, EASTPOINT DENTISTRY; AND CONGRESSIONAL LIAISON, AMERICAN ACADEMY OF PEDIATRIC DENTISTRY, BALTIMORE, MD

Dr. BRILL. Thank you, Mr. Chairman.

Good afternoon, Mr. Chairman, Ranking Member Daines, and members of the subcommittee. My name is Warren Brill, and I operate a pediatric dental practice in Baltimore, MD. I also represent the American Academy of Pediatric Dentistry and serve as their congressional liaison to engage policymakers.

I have practiced for 45 years, providing care to children in Baltimore City and surrounding counties. I fully understand the oral health disparities too many children and their parents face, whether they be racial, cultural, due to disability, economic, or geographic.

I wish to share with you the story of Dawn, one of my patients covered by Medicaid. I first started treating Dawn when she was 13. Dawn is a person with disabilities, and when I met her, she was extremely shy. Dawn came to me with badly decayed front teeth that needed extraction, and in extreme pain with her back teeth. After receiving dental treatment, Dawn communicated more openly, improved her relationships, and was able to better function

at school and work. When Dawn turned 21, she aged out of Medicaid dental coverage, but I kept her in my practice as a pro bono patient.

Our collective experience with access to oral health care likely looks very different than Dawn's. This means we have a responsibility to do more and to do better. I recommend this subcommittee explore 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 one. Second, make sure no child who has significant oral disease and needs dental surgery suffers in pain or risks spread of infection due to lack of operating room access or extensive surgical backlogs. Third, consider options, including tax incentives, to expand the dental workforce.

First, let me address the necessity of early childhood oral health care. While we have seen the prevalence of tooth decay decrease nationally in the U.S., nearly 20 percent of children under the age of five have 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 among persons with disabilities. The American Academy of Pediatric Dentistry and other dental and medical professional groups endorse the importance of having the child's first dental visit on or before age one, to establish a dental home.

The Academy also supports your efforts, Mr. Chairman, to ensure dental care is covered by State Medicaid programs for adults. We firmly believe that if parents receive needed dental care, it will be easier to find a dental home for their children. Dentists also believe that we can further improve Medicaid by addressing audit reform for dentists.

Second, we must further take action to support operating room access for dental surgeries. Given the complex health-care needs of patients I have described and the need for surgery under general anesthesia, the most optimal care setting for these surgeries is in an operating room.

Over the last decade, our challenge as pediatric dentists has been in securing operating room time for dental care, as many hospitals face OR backlogs for as long as 6 to 12 months, with dental surgeons competing for time against medical peers.

I am pleased to inform you that the Academy worked with the broader dental community and those advocating for patients with disabilities to begin addressing this problem with CMS. This year, CMS set up an improved Medicaid billing and payment system to support hospital expenses for dental surgeries. This should allow for more equitable consideration of dental cases. Dentists are asking State Medicaid programs to also adopt the billing and payment changes CMS established for hospitals.

We must also address disparities for people living in rural communities, who must travel long distances to receive hospital-based care. The most viable option is for CMS to permit ambulatory surgical centers, known as 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.

I want to thank Chairman Cardin and Senator Blackburn for engaging CMS in support of this effort. I encourage all subcommittee members to help.

Third, we should consider how tax incentives can support dental workforce development through dental school educators. To address the need for more dental educators in order to build the dental workforce, the Academy has long advocated for student loan repayment and forgiveness options. The average student loan debt for pediatric dentists is as much as $300,000 or more.

As faculty's salaries are significantly less than private practice opportunities, there is a disincentive to enter academia. We encourage the subcommittee to consider additional options to strengthen loan repayment support, such as tax policies. For example, to support a dental faculty loan repayment program, we could exclude the amount of loan forgiveness received from Federal income taxes.

The Academy thanks the chairman for working with us on creative tax policies like this, and we encourage additional efforts to explore tax benefits to grow the dental workforce.

Thank you, Chairman Cardin and Ranking Member Daines, for this opportunity to testify. I will be pleased to answer any questions.

[The prepared statement of Dr. Brill appears in the appendix.]

Senator CARDIN. Thank you, Dr. Brill.

Mr. Forte?

STATEMENT OF JONATHAN P. FORTE, MHA, FACHE, PRESIDENT AND CEO, RIVERSTONE HEALTH, BILLINGS, MT

Mr. FORTE. Chairman Cardin, Ranking Member Daines, members of the committee, thank you for the opportunity to testify. My name is Jonathan Forte, and I am president and CEO of RiverStone Health in Billings, MT.

For over 40 years, health, education, leadership, and protection have been at the foundation of our work. As the health department for Montana's largest city, we lead public health efforts to protect safety and well-being. Our federally qualified teaching health center serves more than 14,000 patients a year across eight locations.

Equitable access to oral health care is not a rural problem or an urban problem; it is an American problem, one that community health centers are essential to solving. Across Montana, health centers are often the only access point for oral health care. Montana's 14 community health centers serve over 120,000 patients annually. That is one in every 10 Montanans.

At RiverStone, we see patients from across the State, central Wyoming, the Dakotas, and other areas across our region, some patients driving over 500 miles to visit a dentist. Recruitment of oral dental providers in rural and frontier areas can take up to 2 years or more. Recently, a health center in Bozeman was unable to retain a qualified dentist because affordable housing, even for someone with a strong professional salary, was unobtainable.

Working with the only two dental-accredited DA programs in the State of Montana, RiverStone and other health centers provide scholarships to those students who commit to serving or working

as a DA or hygienist. Our Eastern Montana Area Health Education Center also provides educational opportunities to students in high school, community college, and technical schools, to build a pipeline of future health-care professionals.

Community health centers provide fully integrated, equitable health-care delivery, and RiverStone Health continues to strengthen collaboration between primary care, dental, and behavioral health. Recently, a patient was in for a tooth extraction, and as our dental assistant was prepping the patient, they expressed a desire to die by suicide. Thanks to our integrated model of care and the compassion of our team, the DA immediately requested a consultation with our behavioral health team, and a therapist was able to visit the patient while in our dental clinic. After the extraction, they ensured that she received the appropriate level of care.

Since the first dental school was founded in the United States, dentistry and medicine have been taught and viewed as two separate professions. The lack of a dental school in Montana creates an additional challenge. In Montana, in our family medicine residency, all residents complete a 1-week oral health rotation with dental providers in our integrated health center. Family medicine physicians actually learn to perform oral health risk assessments and evaluations, and over 65 percent of our resident physicians remain in Montana to work in communities where dental care might not exist.

By increasing the collective knowledge of medical providers about oral health, RiverStone Health can deliver more complete and more equitable care. To truly meet patients where they are though, we must expand utilization of mobile health and deliver oral health care beyond the four walls of the traditional dental office.

Mobile and portable oral health programs have proven incredibly successful, particularly in our schools, providing sealants and screenings to children. In Montana, mobile health units also provide care to farm workers harvesting sugar beets and cherries, as well as nursing home residents. When the Mobile Health Care Act becomes effective in 2024, health centers will be able to expand utilization of mobile units.

However, our success depends on continued funding for new access point grants. Without new access point grants, health centers cannot take advantage of this helpful legislation. Federal investments in health centers reduce overall health spending by expanding access to efficient and effective primary care. If resources are allocated, RiverStone Health and many like us are well-positioned to address unmet oral health needs.

Meeting the needs of our patients and the team that cares for them is what matters to me most as a community health executive. This requires long-term, sustainable, predictable funding to enable confidence in our mission and support the incredible team of dedicated professionals at RiverStone Health and community health centers across the Nation.

Thank you for allowing me to share the current reality impacting our patients and oral health professionals. Your longstanding bipartisan support saves lives. On behalf of RiverStone Health and the Montana Primary Care Association, we appreciate this commit-

tee's commitment to addressing oral health disparities and welcome your questions.

Thank you.

[The prepared statement of Mr. Forte appears in the appendix.]

Senator CARDIN. Mr. Forte, thank you very much for your testimony.

We will now hear from Dr. Farmer-Dixon.

STATEMENT OF CHERAE FARMER-DIXON, D.D.S., MSPH, MBA, FACD, FICD, DEAN AND PROFESSOR, SCHOOL OF DENTISTRY, MEHARRY MEDICAL COLLEGE, NASHVILLE, TN

Dr. FARMER-DIXON. Thank you, Chairman Cardin, Ranking Member Daines, and members of the subcommittee, for inviting me to discuss the urgent need to address disparities in health care. Reports of our Nation's health-care workforce shortage are widespread, and the need continues to grow.

Equally concerning, diversity in our workforce is stagnant, especially within dentistry, which exacerbates existing oral health disparities and supports barriers to care across the Nation. Oral health must be treated as a foundational element of health through incorporation into Medicare and Medicaid coverage.

Today, I will discuss the continuous implications of this shortcoming, and request that Congress join Meharry in solving this critical problem. I am proud to serve as dean of the School of Dentistry at Meharry Medical College, only one of four historically Black medical colleges, and one of only two historically Black dental schools in the United States.

As a current lieutenant colonel in the U.S. Army Reserve with 20 years of service, I appreciate your attention to veterans' health as well. Our college was founded in 1876 with a model of worship of God through service to mankind, and for 147 years we have provided service to the underserved.

Nearly every American will need an urgent trip to the dentist one day. Sadly, not everyone has access to the care they require due to shortcomings in coverage and the absence of diversity. The unfortunate death of Deamonte Driver was a call to action. Thank you, Senator Cardin, for your attention to this event and the policies that followed.

As dentists, we often see patients with dental decay beyond repair and discover life-threatening diseases like diabetes and cancer, first in the mouth. These diseases can be prevented through routine oral health care while reducing an unnecessary strain on health-care resources.

Most Americans without access to dental care come from low-income and minority backgrounds, rural areas, and unfortunately, many of them are veterans. Many studies show vast disparities based on reliable access to care. So, allow me to elaborate.

Over 40 percent of low-income and non-Hispanic Black adults have untreated tooth decay. Forty percent of adults with low income or no health insurance have untreated cavities. The children of low-income parents are three times as likely to have untreated cavities at ages 2 to 5. For these children, poor oral health causes them to miss school and receive low grades.

If left untreated, childhood oral health issues morph into lifelong ailments and lead to the serious diseases that I mentioned previously. At Meharry Medical College, our mission is to serve, which we uphold by routinely caring for our low-income and uninsured community.

Every spring and fall, Meharry holds the largest oral health days in the Nation, where our dental students, our alumni, and our teachers donate free dental care services. For many, these oral health days are the only opportunity to receive dental care. This does not adequately address oral health disparities plaguing our communities.

We cannot reach the many dental care deserts across the Nation where care is neither affordable nor approachable for minority groups. A key solution is increasing the diversity of our dental workforce. It is well-established that a person's health care and trust in the medical community improves when they are seen by a provider of their own race.

When given a choice, people are far less likely to visit a dentist of a different race, and that means that many visit only when they are in the worse circumstances. Currently, only 4 percent of our Nation's dental workforce is Black. That is barely one Black dentist in every major city in the U.S., and 27 percent of those dentists have been educated at Meharry.

The job of educating a diverse dental workforce cannot rest solely on Meharry and our sister HBCU, Howard. Dental education and affordable care must extend on a national level. We need Congress to focus on finding a solution and improving oral health nationally. Failure to act aggressively will lead to sicker Americans and an additional strain on our health-care system. We urge Congress to join us in creating a more diverse health-care workforce, and a health-care system with comprehensive care and coverage for dental.

Meharry Medical College promises to be a steadfast partner and leader in this work. We have the legacy, expertise, and knowledge to lead this effort, so that all children of tomorrow can visit their local dentist with confidence, trust, and free of fear.

Thank you for the opportunity to speak with you, and I am happy to answer any questions.

[The prepared statement of Dr. Farmer-Dixon appears in the appendix.]

Senator CARDIN. Thank you very much for your testimony.

Dr. Vujicic?

STATEMENT OF MARKO VUJICIC, Ph.D., CHIEF ECONOMIST AND VICE PRESIDENT, HEALTH POLICY INSTITUTE, AMERICAN DENTAL ASSOCIATION, CHICAGO, IL

Dr. VUJICIC. Chairman Cardin, Ranking Member Daines, members of the committee, I really want to thank you for inviting me to share some data-driven insights on oral health in America. More importantly, I want to thank you for holding this hearing. It is a recognition of the important role of oral health in overall health and well-being, but also a testament to the need for action.

I think all of us would agree here today that when it comes to our Nation's oral health, we can and we should do better.

My name is Marko Vujicic. I am the chief economist and vice president of the Health Policy Institute at the American Dental Association. I lead a research team that studies the U.S. dental care system. In this role and throughout my career, I have worked on bringing evidence and data to policymakers to help inform decision-making.

My written testimony covers several important aspects of our dental care system and the topic of today's hearing, including trends in oral health, what is happening to disparities over time, what are some unique challenges in rural areas that we have heard a little bit about already. I have also laid out some considerations for policymakers as you think about solutions and the path forward.

Now, my written testimony is heavy on data, statistics, and research, and I am happy to discuss it later on in detail. But in my opening remarks, I want to make one point and one point only, and that is, when it comes to our Nation's oral health, what we see today is a result of the policy choices we have made along the way.

And namely, when it comes to children, we treat dental care as core health care, as an essential service. And when it comes to adults and seniors, we do not. So, in America's health-care policy, essentially we disconnect mouth from body when people become adults.

It is precisely because of these policy choices along the way that, in fact, oral health in America is a two-part story. As you will see in my written testimony—or if you have seen—when it comes to children, the data show some appreciable gains that we have made over time. We are certainly not out of the woods, but oral health is improving, and more importantly, disparities in many aspects of children's oral health are narrowing by race, by income. As Chairman Cardin said in his opening remarks, for adults and seniors, we are not seeing that.

Our policy choices also have repercussions that extend well beyond the mouth. Every year, there are more than 2 million hospital emergency room visits in America for oral health conditions. If we do the math, that is about one every 15 seconds.

This is heartbreaking, but as an economist I also want to highlight that this costs our health-care system upwards of over $2 billion per year. Research also shows that improved oral health can lead to cost savings on the medical care side. We have heard this already for conditions like diabetes, heart disease, pregnancy.

And maybe most shockingly, 3 out of 10 low-income adults in this country—3 out of 10—say that oral health conditions limit their job prospects. So these data suggest quite strongly that we are paying an economic penalty for our policy choices along the way. Put another way, aside from improving people's lives, there is an economic and fiscal dividend associated with improving our Nation's oral health.

So, on behalf of the American Dental Association and my team back home in Chicago, I want to thank you for the chance again to share some data-driven insights, and I again thank you for holding this hearing. I am happy to elaborate further on any points in my testimony or answer any questions.

Thank you once again.

[The prepared statement of Dr. Vujicic appears in the appendix.]

Senator CARDIN. Let me thank all four of you for your contribution to this hearing. I particularly appreciate some of the specific recommendations that you have made, and we will certainly be looking at those specific recommendations.

Dr. Vujicic, I could not agree with you more about the division between our young people and our adults and seniors. We had a choice to try to make some progress during the CHIP program, which obviously deals with our children, and we were able to get some progress done there for pediatric dental.

And then in the Affordable Care Act, we had a chance to include the pediatric dental. We tried to do more; we were unsuccessful in getting more included. But I think your point is very well taken. There are some efforts now to deal with this through Medicare and through Medicaid, to expand coverage for adults, and that is an issue that is currently being debated here in Congress.

And, Dr. Brill, your three recommendations. Your first was that we need to have young infants to 1-year-olds connected with a dentist by that time. And one way you said to get that is for their parents to have coverage and a dentist, but many of the low-income families do not have a family dentist. So therefore, their 1-year-old is less likely to have a dentist.

So I think there is a direct connection between providing adequate coverage for our adult population and being able to get our children adequately covered. So I thought those points were just very well taken.

There is also another aspect here, and I wonder if you all wanted to comment on it. We found that health literacy is not where it needs to be. Sometimes we find our children know more than their parents know by the mobile dental lab buses that go around to our schools. Has that been effective?

I know in Maryland, we use the mobile dental facilities to go to our schools, and it helped the children, but it also helped the children's parents understand oral health care. Do you all have any experience on the advantages of mobile dental?

Dr. BRILL. The mobile dental programs do help, but they do not establish a dental home. So the best way to get the children to be healthy, especially via the parents, is to bring them to the dental office at age 1 or eruption of the first tooth.

If they see the mobile dentist, they do not necessarily receive care, but are told that they might need care. So, it is a good first step, but it is not the solution. The solution is to find a dental home at age 1 or at the eruption of the first tooth.

Senator CARDIN. Dr. Farmer-Dixon?

Dr. FARMER-DIXON. Yes. We have a mobile dental unit, and the premise is that we want to meet people where they are, and going into those rural communities, remote areas where they do not have access, but going on a regular basis so that they know that, while it is a mobile unit, it can serve as their mobile home.

So it is for the family—to your point, the literacy for the adults and educating them so that they will understand the importance of oral health, not only for themselves, but for their children as well, so that we are making it a family approach to addressing their dental needs.

Senator CARDIN. So, I was at a behavioral health center this past week, and their number one concern was workforce, getting health-care professionals. I have been to our hospitals. Their number one concern is the workforce, getting workers. Everywhere we go, we have a shortage in the health-care fields.

So is there something unique about dentistry that we should be aware of in our effort? You mentioned those who are teaching dentistry. We had the same concern about those teaching nursing, that it is just economically not as rewarding. A nurse can make more practicing than they can teaching.

Is there something special about dentistry that we should be trying to help in regard to the workforce?

Dr. BRILL. Well, one of the main obstacles in the workforce right now is the result of COVID. Many, many people either are not coming back into the field or not entering the field. So we have to be able to educate the population and the workforce that this is, if not under control, getting under control.

In terms of the dentists themselves, as I mentioned earlier, the student debt is a big problem. There are programs that are in place now to help, but they need to be expanded and enhanced. Those are some of the things that will help ameliorate the situation of a decreased workforce.

Senator CARDIN. Let me ask Mr. Forte: you do not have a dental school, if I understand correctly, in Montana?

Mr. FORTE. That is correct.

Senator CARDIN. So, we generally learn that where people train, they are more likely to stay. What do you do to attract dentists in Montana?

Mr. FORTE. So, with the family medicine residency—that is right—we train family practice physicians, and we keep over 60 percent of them in Montana. With our dental program, we go outside the State, and actually outside the Mountain West region, and partner with schools like the University of Washington School of Dentistry and the NYU Langone Advanced Education in General Dentistry Program.

NYU Langone actually specializes in providing resident student dentists to community health centers like RiverStone Health across the country and focuses on rural and underserved locations as well. So, through partnerships and collaboration, we are able to bring students into Montana, expose them to the wonders of our State and our community, and hopefully they choose to stay there and raise their families.

Senator CARDIN. And also, their outstanding representatives in the United States Senate.

Senator Daines?

Senator DAINES. Chairman Cardin, I was going to say a fly rod and a set of skis is also a way we recruit dentists to Montana at times. But thanks for your kind words, Mr. Chairman.

So, I spoke a bit in my opening comments about how crucial health centers are to addressing health-care disparities across the country, especially in more rural States. As you said, we do not have a dental school in Montana, where receiving care often means driving several hours to see the nearest health-care provider. RiverStone Health in Billings is a leading example on many fronts,

including the access to dental services. But as has already been discussed, providing that care has its difficulties and challenges.

Mr. Forte, from your perspective, what are some of the greatest challenges for health centers when it comes to providing access to dental services in States like Montana that do not have a dental school? What are your thoughts?

Mr. FORTE. Senator, it is obviously access to care. Like you stated earlier, due to our geographic nature and the distribution of dental providers, it is, "Do I live close enough to a dentist or am I in a town that has a dental provider within it, or do I have to drive to a larger city like Billings or Helena?"

Due to our vast geography, another challenge is that only 30 percent of Montanans are actually exposed to fluorinated water. Community water systems are common in our larger cities and towns, but the majority of Montanans are on cisterns or wells, making fluoride toothpastes and school-based dental sealants and sealants for children a priority. That is one of the ways that we combat that issue.

I think patient perception of a need to see a dentist is also an issue across the country, as well as how much it is going to cost. We have conversations with our patients almost every day. "I am worried about how much this is going to cost me. I do not want to come back next week. Could I come back a month later? I will be able to afford it then."

Less than half of Montana's low-income adults reported seeing a dentist last year, and across the U.S., emergency dental visits for preventable conditions cost our health system nearly $2 billion. Montanans aged 18 to 39 rely on emergency dental care more than any other group.

So, at RiverStone Health, it is important to us to get into schools, to provide access points, early childhood care programs, and comprehensive oral health education, to not only our students but also adults. With this mobile program, the problem I see in school-based dental programs is that adults are not consenting for their children to be treated, because they lack that health literacy about why dental care is important.

Senator DAINES. So you spoke a bit about mobile services. I know you have experience utilizing mobile clinics. I have seen that in Montana with some of the seasonal workers who work the Flathead cherry crop. If we did not have those seasonal workers, we would not have the joy of the cherries every August in northwest Montana.

I have seen those mobile clinics take care of some of those seasonal workers. Could you talk a bit more—you alluded to it a bit—about the approach to providing care, and the success or limits you have seen with mobile clinics?

Mr. FORTE. Yes, absolutely. And in previous roles in community health, we have built mobile vehicles, specifically in Maryland. We built those vehicles during ARPA funding for community vaccinations through COVID, and then quickly realized the need to roll those out with a dental package on board, to go to area schools and serve over 36 schools on the Eastern Shore. It is a great program.

Half of all school-based dental programs in the U.S. do not use a mobile unit. They use a small, portable suitcase-like device to go

in and provide cleanings, screenings, and sealants in the janitor's closet, an empty classroom, the school auditorium, or the gymnasium—anywhere that that school has the ability to provide them with an access point.

The mobile units truly provide a safe space, a controlled environment. And really, kids get excited when they see them pull up out front and know that the dental team is there to take care of them that day.

Our mobile programs, once they are developed, I think the biggest challenge, like I said, is consent. If we are going out and we are providing access in the schools, we need parents to be educated about the program and know what benefit it will provide.

Senator DAINES. All right.

Mr. Chairman, thank you. I might note that this is probably the first witness you have seen who mentions Montana and Maryland as the only two States in his testimony. [Laughter.]

Senator CARDIN. I knew we had a lot in common. That is good.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman. Another great M State, Michigan, so we will just keep going here. Welcome to all of you. I first thank you, Mr. Chairman, for all the work you have done on oral health over the years. I am proud to be your partner in this.

I enjoyed working with you very much, and also, it is great to have Senator Daines again as the ranking member of the subcommittee. I appreciate very much the work on the behavioral health workforce that we were able to get done at the end of the year. So, a lot more to do on all of this.

So, we are here because we know that oral health is health care, period, and we need it to be for children and adults and seniors. We need to make sure that we are treating it as such. But we also know that, obviously, people are lacking care and the affordable services that they need.

So I am very pleased to lead efforts with Senator Cardin to improve oral health for moms, and we know that there is a positive impact on children in the connection with their moms.

So, our Oral Health for Moms Act seeks to improve maternal oral health and, consequently, children's oral health. It would require Medicaid and the Children's Health Insurance Program to cover dental health care for pregnant and postpartum women and require that health insurance provide coverage of oral health to pregnant women as an essential health benefit.

And so, I am really pleased that right now all State Medicaid programs cover dental care during pregnancy and 60 days postpartum, which is great, but there is more to do. So, Dr. Farmer-Dixon, I wonder if you could elaborate on the connections we have been hearing about today between an adult caregiver's oral health and what happens to their children?

Dr. FARMER-DIXON. I think a lot of times, with expectant mothers especially, because they are going through hormonal changes, there are things that can happen in their mouth, like periodontal disease. And they need to go to the dentist on a regular basis, just like they are going for their regular evaluations during and throughout their pregnancy.

So I think that it is twofold. There needs to be an education and a professional training among the physicians and the dentists, so that it is a holistic approach to providing care, so that when those expectant mothers are going, it is a natural progression that if they do not have a dental home, they also are connected with a dentist so that they are getting routine evaluations throughout their pregnancy.

The other thing is that if they have a lot of cavities in their mouth, that means that they have a lot of what we would call bad bacteria, and there is the potential for that to be transferred to their unborn child. So unfortunately, then that child is coming in with some potentially bad bacteria and having a higher risk of getting dental decay.

Even after the pregnancy, just the education—we talked about literacy, when it is a team approach to health care, not just the pregnancy but the child, and educating so that they know that there is a potential for baby bottle caries. They may think that they are providing healthy milk and juices, but because they are high in sugar content, they are potentially exposing their children—not intentionally, but due to a lack of knowledge.

So it really needs to be a holistic approach to how we are looking at the health care of the expectant mother, and them understanding—and not just the mother, but the health-care team—working collectively to make certain that throughout the pregnancy and beyond, that it is a healthy child, and a healthy child means that they have a healthy mouth, that the mother has a healthy mouth, that the child becomes a healthy adolescent that includes oral health and a healthy adult.

Senator STABENOW. Thank you so much.

Dr. Vujicic, you mentioned in your testimony that dental coverage for adults is not currently an essential health benefit under the ACA or universally covered in Medicaid. Could you talk a little bit more about the effects of expanding that coverage to adults?

Dr. VUJICIC. Well, Senator, as you mentioned, the landscape currently is 29 States provide dental coverage to adults that we consider extensive in our analysis, in their State Medicaid program. You mentioned it is voluntary. We know that when States expand coverage and add dental benefits for adults in their Medicaid programs, it improves job prospects, most among Black beneficiaries.

So there is definitely a reduction in disparities there. We know it reduces emergency room costs. Senator Cardin, in your State, we had the pleasure of teaming up to do some research. We estimated a $4-million savings per year to the Medicaid budget by expanding adult dental. Those are a couple of examples of what I call the fiscal dividend.

Senator STABENOW. Thank you.

And as I conclude, let me just say community health centers are so very important, Mr. Forte, and our Oral Health for Moms Act would also add new grants for Federally Qualified Health Centers as part of what they do. So, thank you for what you do in integrated care. We are hoping that Montana is going to be part of a broader community behavioral health clinic effort now that is happening, and with my Agriculture hat on, I have to say "thank you" for being a beekeeper.

Senator CARDIN. Well, we are joined by the chairman of the Senate Finance Committee. We have been talking about a lot of the progress that we have made, whether it was through the Affordable Care Act—which, by the way, provided substantial increase of funds for the qualified health centers—or whether it was the CHIP program, or whether it was some of the bills that were passed in the last Congress.

It was Senator Wyden's leadership that marshaled those successes to the finish line. So we are very proud of our chairman.

Senator Wyden?

Senator WYDEN. I do not want to make this a bouquet-tossing contest, but the fact is Senator Cardin has been after these issues for years and years, before they became popular, before they were debated on the floor of the Senate and the House. I just want him to know how much I appreciate him being in these critical health precincts for so long, and we are so lucky that he is going to be the chair of this important subcommittee.

I was listening to the Ms getting rolled out. I heard Maryland, Montana, and then Michigan. I said, "Well, I do not really get to participate in that, because Oregon is not in the M department." But I want to talk about Medicare, so we will kind of stay with the Ms, and I want to put this in this context.

Before he retired, the late Orrin Hatch was willing to talk to me about chronic illness. And I laid out a plan that essentially involved the proposition that when Medicare began in 1965, it was largely acute illness: you break your ankle, you go to the hospital; it is Part A.

But most of Medicare today is now chronic illness: cancer, diabetes, heart disease, strokes, dental challenges. So I went to Chairman Hatch and I asked him about passing a major Medicare reform bill called the CHRONIC Care Act.

He looked at me—he always treated me like his son, and I think Senator Cardin remembers it—and he smiled, and he said, "That's even more ridiculous than anything Kennedy used to ask me to do." I said, "Mr. Chairman, I think we can do this. I think we can do it in a fiscally responsible way." And in fact, we did get it passed. It was one of his last major pieces of legislation.

The fact though is that it did not really put us in a position under this legislation—for example, it had major provisions on telemedicine. And when Seema Verma, Donald Trump's Secretary of Health and Human Services, called me up and said, "Can we use it as the telemedicine standard for COVID?", I said, "Thrilled, terrific. But what about this other stuff?" She said, "Well, it is COVID. We cannot do it." Now we are in a position where we can.

Doctor, if you were to amend the CHRONIC Care Act going forward today to incorporate the kinds of good work that Senator Cardin has been talking about in terms of say, dealing with chronic dental disease, what would you put in?

Dr. FARMER-DIXON. I think there has to be coverage for adults. Just as with telemedicine, teledentistry would be a component of being able to reach those communities and create greater access and connect them with dentists. I think also in doing that, by creating greater access for adults, you have to have the workforce to

be able to treat those individuals, and that goes back to increasing the diversity of the workforce.

When we talk about our chronic diseases and the most vulnerable populations, those are poor individuals. Those are the low-income. Those are Black and Brown communities. So, giving them access and expanding Medicare is a step in the right direction. But the other component of that is that giving them that access, they have to also have a provider that they can go to, and we have to look at how we increase the workforce—how we increase the diversity of the workforce as well.

Senator WYDEN. I think your answer is spot-on, and I would be interested in any information you have or could supply. I do not want to force you to write a book report or something, but the teledentistry model, particularly, is something that would be a next stop for the CHRONIC Care Act, and the next stop for telemedicine.

It makes a lot of sense, and I would love to be one of the cosponsors of a Cardin bill on that, because I think it is very good. My time is almost up.

The only other point I want to make, Mr. Chairman—why I think it is so important that you are doing this work—is, I have been struck now by the number of people who apparently are going to hospital emergency rooms suffering from dental disease. You talk to the physicians there, and they say—I went to school on a basketball scholarship. They would tell you it is like playing out of position.

The emergency physicians are going to give people good care. They are committed to the health of the people they see, but they are not really trained to do it. And then they would say, "Ron, you know, I can help people deal with the immediate challenge when they are dealing with tremendous disease, and I can make sure that they get a cleaning, and particularly get medicines so that they can deal with an infection." And then they tell you the real clincher: they are going to be back here in 6 weeks, because we do not deal with the problem comprehensively.

So my time is up. I just wanted to come by for a few minutes on a busy day, because I am all-in for Senator Cardin's program.

And on teledentistry, Dr. Farmer-Dixon—and I apologize for not getting into more detail with all of you—I think we have a chance now to take what is the future of Medicare, which is chronic disease, figure out the next steps beyond where Chairman Hatch was willing to be really gutsy and do something with the fellow on the other side of the aisle, and it would be good for telemedicine.

So, I really appreciate all of you, and I am looking forward to being one of the cosponsors of a Cardin bill on something like this.

Thanks, Ben. Thank you.

Senator CARDIN. Thank you, Senator Wyden. I appreciate very much your support and your leadership on this issue. Teledentistry is an interesting subject. We are moving forward. Under Senator Wyden's leadership, we have moved forward to expand the COVID-related telehealth services beyond COVID.

I expect there are going to be further activities done at the Federal level to try to remove obstacles in the system, whether they

are certification issues going across jurisdictions or reimbursement issues on telehealth.

So for teledentistry, I look at the model today on payment, which is very mixed. You have, obviously, some coverages under the CHIP program and under the Affordable Care Act. You have some Medicaid coverage, and you have some private insurance coverage, and you have private pay. What are the obstacles to teledentistry? I take it it is used for a lot of the follow-up care for dental maintenance, et cetera.

So, what are the obstacles today to expanding the use of telehealth, which could be pretty important for communities where transportation is difficult for people to get to a dentist?

Dr. BRILL. Teledentistry is very, very helpful when it comes to diagnosis. I learned from the very beginning you cannot diagnose over the telephone, but you can make a very good stab looking at a photograph on your cellphone. When it comes to the actual treatment, that is where the rubber does not meet the road, because you have to have the patient in the chair.

But it certainly can alleviate a lot of the chair time that might not be productive in terms of the health outcome. So it has a place, but unlike other avenues or other specialties, it is an adjunct but it is not the end of what can be done.

Senator CARDIN. Anyone else with—yes, Doctor?

Dr. VUJICIC. Senator, just looking forward, I think the opportunity comes with perhaps reforming the payment model. You hit a very important point there. If the system navigates to a payment model that is somehow rewarding health or connectivity with providers, rather than simply paying for procedures and surgeries, all of a sudden now the incentives change for teledentistry.

I agree totally. We saw it primarily with COVID and post-pandemic. It is like a triage tool, right, to stay connected to patients. But you are totally right. The payment model is limiting its take-up, and I see a bright future if we can tweak the payment model.

Senator CARDIN. So, I will put a promo in for Maryland. Maryland has a total cost of care model that came out of its hospital reimbursement structure which is now well beyond hospital care, and it is based upon that. You can find less expensive—quality must be maintained—but less expensive and more efficient ways to do business; you can do it.

Of course, that is also true on some of our efficiency models in the Affordable Care area. So we do have some models out there that reward that type of reimbursement, but not enough. Good point.

I want to go back to the point that Dr. Brill mentioned on the lack of surgical space for dentistry, because that is absolutely true in Maryland. I have heard that over and over again. So, Dr. Vujicic, let me ask you whether this is a national issue or just one that is unique to a couple of States.

Do we have a serious problem of dentistry not getting its fair allocations of surgical space within our hospitals?

Dr. VUJICIC. Yes. This is one of those that is not on my fingertips, but the team can get back to you on that. We certainly saw it as a national issue. We do not know how much it varies across

States, and we have been supportive of legislation. Our DC team is here, so we can follow up on that.

Senator CARDIN. Dr. Farmer-Dixon, have you run into that issue in your work?

Dr. FARMER-DIXON. When we are talking about dentistry and establishing it in a hospital setting—you know, unlike a medical room or an examination room—you have your examination chair. So there are other factors that come into play that are associated with cost.

So when you are talking about setting up a dental chair or dental clinic, you are talking about adequate plumbing for suction, vacuum units, compressors, water lines—at additional cost in comparison to maybe setting up a medical clinic.

And so, while in some instances the idea or the concept is great, when you start looking at how you are going to logistically develop that and execute that plan, you get into additional costs that a lot of times people—unless they are in the dental profession or understand dentistry and what it takes to actually set up a dental clinic—do not expect those costs, those additional costs.

Senator CARDIN. Mr. Forte, in a rural area like Montana, do you have challenges in getting surgical space?

Mr. FORTE. Absolutely, and you know, a lot of our private dentists across Montana do not actually do extractions, and so patients are forced to go to an oral surgery center somewhere. The great vast geography of the State of Montana precludes that easy access most times.

We do have a part-time oral surgeon on staff at RiverStone Health, and that provides some of the only access to oral surgery and greater, higher-level procedures that some of our patients require. So, anything we can do to improve access to OR space or improve oral surgeons coming into rural and frontier regions would be greatly appreciated.

Senator CARDIN. And, Dr. Brill, I have found that medical politics can be more brutal than politics in the Senate. So is this a medical turf problem, or is this a situation where we can help you?

Dr. BRILL. I think it is probably both. We compete for operating room time with surgeons. Fortunately, at my hospital—which is part of the University of Maryland system—there is a dedicated operating room just for dental cases. But that is not the case throughout the State or the Nation. Shady Grove Hospital, which is in our State, discontinued all dental cases in the recent past.

So there are children who need care. We do not know where to go. I have a national reach within my organization, and this is a national problem in terms of operating room access, which is one of the reasons that we are hoping that the new code and procedures that CMS put in for Medicare for hospital reimbursement for operating rooms will also be applied to ASCs, which I believe is something that you and Senator Blackburn are working on.

Senator CARDIN. Thank you.

Senator Warren, it is nice to have you here. Thank you.

Senator WARREN. Thank you very much; thank you. I appreciate it, Chairman Cardin.

So, since Medicare was established in 1965, it has not covered routine dental benefits. That means no fillings, no extractions, or

even preventive care like cleanings. As a result, seniors are more likely than any other age group to lack dental insurance, and nearly half of all Medicare beneficiaries, about 24 million people, report that they did not have dental coverage in 2019.

Now, while Medicare is prevented from covering almost all dental benefits, the government has created an exception for the private health insurance plans that offer Medicare Advantage or MA. Under this system, MA plans can offer supplemental benefits that cover services that are not available under traditional Medicare, and not unsurprisingly, dental benefits are a very popular offering. In fact, 96 percent of MA enrollees were in plans offering some dental coverage in 2022. But even seniors who are able to access dental services may face hurdles in getting the care that they need.

Dr. Vujicic, almost all MA beneficiaries are in plans that offer dental care. We have almost all of them. But what do we know about the quality of the coverage they are getting?

Dr. VUJICIC. In a nutshell, the research suggests strongly that Medicare Advantage dental has very little impact on utilization of dental care, as well as oral health outcomes themselves. I could elaborate more.

Senator WARREN. But tell me the principal reasons why that is so.

Dr. VUJICIC. Well, for example, a third of those plans have cost sharing for prevention. When they do offer more than prevention—fillings, extractions, like you said—the most common co-insurance rate is 50 percent. So I mean, I challenge us to think—if a heart valve replacement was 50 percent co-insurance, we certainly would complain about affordability of cardiac care. Those are some of the key parameters in the——

Senator WARREN. Okay, okay; dollar cap, service frequency limits, required copays——

Dr. VUJICIC. Correct.

Senator WARREN. All right; very helpful. In fact, a new study found that seniors in MA used even fewer services than beneficiaries in traditional Medicare. So, while millions of Medicare beneficiaries do not have access to dental care, the ones who do may have such high out-of-pocket costs that effectively they do not.

According to the Kaiser Family Foundation, Medicare beneficiaries who use dental services paid about $875 in average out-of-pocket costs in 2018. One in five spent more than $1,000.

Dr. Farmer-Dixon, in your experience as a dentist, if a patient faces high out-of-pocket costs, are they more likely or less likely to get the care that they need?

Dr. FARMER-DIXON. They are less likely to get the care that they need, because they cannot afford those out-of-pocket costs.

Senator WARREN. Okay. So seniors are more likely to avoid getting dental care if they know it is going to mean spending a lot of money out of pocket. It seems to me the solution is clear. It is time to expand Medicare to cover dental care, something I have long supported.

But critics say it is going to be too expensive. But the truth is that MA plans have been overcharging Medicare for years, and the most recent reports suggest they are going to wrack up nearly a trillion dollars in overpayments by 2031.

And it will not be just taxpayers who foot the bills for these overpayments. Medicare beneficiaries will also pay nearly $150 billion in higher Part B premiums. So, Dr. Vujicic, how much would it cost to add a dental benefit to Medicare?

Dr. VUJICIC. The estimates range from $23 billion per year up to $32 billion per year, depending on how the benefit is designed and the parameters, et cetera. But that is the range from the research.

Senator WARREN. Okay. So $23 billion to $32 billion a year, or we can spend nearly a trillion dollars in overpayments to insurance companies for crummy coverage that beneficiaries do not use. Or we can crack down on the abuses and use this money to pay for the dental care that people actually need.

Now, CMS has recently proposed a rule that takes steps to ensure that payments to MA plans more accurately reflect the cost of providing care. CMS should absolutely finalize this rule. But I want to argue here that CMS needs to go further and end these insurance industry scams and ensure that beneficiaries get the care they need. We could use this money to provide the dental care that people across this Nation need.

I appreciate all of you being here. I appreciate you for holding this hearing, Mr. Chairman. There is such an obvious way for us to provide a solution here if we just have the political will to get it done.

Thank you. Thank you, Mr. Chairman.

Senator CARDIN. Senator Warren, thanks for the points that you made. I totally agree with you. Your numbers are extremely conservative, using 2018 numbers, which would be likely higher today. The number that you got on the cost of extending Medicare to cover dental is the direct cost to Medicare without all the savings.

This hearing has pointed out that we are going to get savings in so many other areas of health care, including diabetes, heart disease, pregnancy complications, things like that, which will save dollars, not to mention the fact we have talked about the emergency room use for dental care, which I can tell you in my State of Maryland, it is major problem in our emergency rooms with dental care being provided.

So that is terribly inefficient, very costly. So the numbers that have been given to you do not take that into consideration. In one of the bills that we are working on—Senator Whitehouse is trying to help as chairman of the Budget Committee—the way that we score some of these programs is to look at it from a more holistic point of view, as to the type of savings it brings in.

I use the example of the CBO today. If you did not have an annual physical coverage under Medicare, and we put a bill in to do that, it would be scored for hundreds and hundreds of billions of dollars, and we know it saves money.

So we need to change the way that we score these programs, because it is just common sense that to get people in to see a dentist is going to save money. They are going to be able to work, we eliminate the loss of time from work—all the different losses that we have because people are not getting just the routine care.

So I thank you for making that point. I hope we will see the day that we can expand Medicare to include dental, and we were close,

I thought, in the last Congress, so we are going to have to keep working at it. Thank you for the point.

Senator WARREN. Thank you for your leadership on this.

Senator CARDIN. And let me thank all of our witnesses. Let me just check to see if I have to do anything else formally.

[Pause.]

Senator CARDIN. We will keep the record of the committee open for 1 week in case members have questions for the record. We would ask the witnesses, if they get questions for the record, to please respond to them quickly. You may be saved because we are going into a recess, so we scatter pretty quickly after tomorrow, so I think we will be safe.

But the record of the committee will remain open for 1 week for questions for the record. And again, I thank our panelists for being here today. It was, I think, extremely helpful. I wrote down your suggestions, and working with Senator Daines, I hope that we will be able to advance some of these issues during this Congress.

And with that, the subcommittee will stand adjourned.

[Whereupon, at 4:03 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF WARREN BRILL, DMD, OWNER, EASTPOINT DENTISTRY; AND CONGRESSIONAL LIAISON, AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

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.

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.

---

[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.

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.

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

---

[2] American Academy of Pediatric Dentistry, Definition of dental home, The Reference Manual of Pediatric Dentistry, Chicago, IL: American Academy of Pediatric Dentistry; 2022:15.

[3] Vargas C.M., Ronzio C.R., 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.

[5] *Ibid.*

[6] Hill B.J., Meyer B.D., Baker S.D., 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 B.J., Finlayson T.L., Decker S.L., Manski R.J., Yang M., The Association Between Medicaid Adult Dental Coverage and Children's Oral Health, *Health Affairs* (Millwood), November 2021.

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.

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 6 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.

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

[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.*

[10] 87 FR 71748 (November 23, 2022).

[11] CMS established CPT G0330 (dental rehabilitative surgery) and associates the code with APC 5871 for dental procedures.

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 5 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 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.

QUESTIONS SUBMITTED FOR THE RECORD TO WARREN BRILL, DMD

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. COVID–19 upended daily life and continues to impact our communities and our health-care system today. What are some lessons learned from the pandemic about oral health care and access to oral health care that the committee should be aware of?

Answer. Over the course of the pandemic, dental service use among children covered by Medicaid and CHIP was down about 20 percent on average. Dental services took a greater hit than other primary care services, such as vaccinations for children

---

[12] *Ibid.*

[13] Dentists of Tomorrow 2022, American Dental Education Association, September 2022, available at *https://www.adea.org/Seniors2022/*.

(down about 11 percent). Dental service use has not fully recovered since the pandemic.[1] As of 2023, children are not yet back to regularly seeing dentists, receiving preventive or restorative care they need at the rate they were pre-pandemic. The mandated closure of my Baltimore-based dental office had a negative effect on my patients' oral health in that care could not be accessed in a timely fashion. Additionally, many parents did not bring their children into the office immediately when we first reopened our practice as families were initially unsure of possible exposure to the virus, even though we utilized and publicized all ADA and CDC recommendations for infection control. It is important to note that the dental community has long been a leader in infection prevention and control, looking back to the AIDS epidemic in the 1980s. While most dental offices were mandated by their State authorities to close for at least some time during the COVID pandemic in order to preserve personal protective equipment (PPE) and control the spread of the virus, dentists and their teams were well prepared to maintain a safe environment for patients and families. Studies of dental teams early in the pandemic indicated low COVID–19 prevalence.[2] In any future pandemic, the AAPD strongly recommends that oral health be deemed an essential health service rather than an elective service. Children's access to needed oral health care was halted as a result of dentist office closures, and children's health suffered greatly as a result, and the effects are long-lasting.

COVID–19 accelerated the adoption and usage of teledentistry. One year into the pandemic, three out of four pediatric dentists had incorporated teledentistry into their practices to reach more patients while minimizing risk of infection.[3] Dentists put technology to use to triage emergencies, efficiently do post-op and follow-up care, perform consults, and educate patients. Since the end of the public health emergency (PHE), many practices have reduced their reliance on teledentistry, especially as coverage and payment has shifted following the end of the PHE.

AAPD views teledentistry as a valuable tool to improve access to care for pediatric patients, especially infants, young children, adolescents, and individuals with special health-care needs when circumstances create barriers to care.[4] Additionally, the AAPD believes teledentistry is useful in addressing time-sensitive injuries such as trauma or when unexpected circumstances result in difficulties accessing care. However, the AAPD views teledentistry as an excellent adjunct to in-office dental care, and believes it does not and cannot replace a patient needing or having a true "dental home" for complete, comprehensive, and ongoing oral health care.

The AAPD also believes strongly that for teledentistry to remain an effective option for dentists and patients who benefit most, it must be included as an essential component of health care benefits plans with reimbursement parity to in-person delivery of care.

Question. As States resume redetermining who is eligible for Medicaid this Spring, we know that many people will lose their Medicaid coverage. Some will lose their coverage even if they are still eligible for it just for procedural reasons.

How will these changes impact access to oral health care?

Answer. Medicaid "unwinding" and the end of continuous eligibility has been and will continue to be a concerning period for all invested in the health, well-being, and social supports of our most vulnerable populations. While complete data on coverage loss is not yet available from CMS, the Georgetown University Center for Children and Families estimates that 5–7 million children could lose Medicaid or CHIP coverage, with the majority of them being improper removals from coverage where the

---

[1] Medicaid and CHIP and the COVID–19 Public Health Emergency: Preliminary Data Snapshot for Services Through July 2022 (page 24). CMS, *https://www.medicaid.gov/sites/default/files/2023-02/covid-19-medicaid-data-snapshot-07312022.pdf*.

[2] Estimating COVID–19 prevalence and infection control practices among US dentists. Estrich, C.G., et al. *JADA*. November 2020, *https://jada.ada.org/article/S0002-8177(20)30658-9/fulltext;* Infection Prevention and Control Practices of Dental Hygienists in the United States During the COVID–19 Pandemic: A Longitudinal Study. Estrich, C.G., et al. *JDH*. February 2022, *https://jdh.adha.org/content/jdenthyg/96/1/17.full.pdf*.

[3] COVID–19 pandemic related dental practice trends on teledentistry. American Dental Association Science and Research Institute and American Dental Association Health Policy Institute. Poster presentation, May 2021.

[4] Policy on Teledentistry, *https://www.aapd.org/research/oral-health-policies--recommendations/policy-on-teledentistry/*. The Reference Manual of Pediatric Dentistry. Chicago, IL: American Academy of Pediatric Dentistry; 2022:50–1.

family continues to meet eligibility criteria.[5] Without Medicaid (including pediatric dental) and its mandatory coverage requirements for children's oral health care through EPSDT, families are much less likely to be able to get dental care due to cost concerns.

The vast majority of pediatric dentists are Medicaid providers. The American Academy of Pediatric Dentistry has been educating its members on how to be prepared to support patients and families through this turbulent time as Medicaid eligibility is redetermined for so many families by States.[6] Pediatric dentists are embracing the opportunity to connect their patients to services in the community to maintain health coverage and ultimately maintain good oral and overall health.

Question. Oral health is integral to overall health. Older adults and people with disabilities have some of the worst access to oral health coverage and oral health care, with particular inequities in access for people of color. For example, prior to the pandemic, 7 out of 10 Black Medicare beneficiaries and 6 out of 10 Hispanic beneficiaries reported they haven't seen a dentist within the past year.

Can you speak more about how older adults and people with disabilities are affected by a lack of affordable or accessible oral health coverage, particularly since oral health can impact other underlying conditions?

Answer. The former Surgeon General Koop said it many years ago: "You're not healthy without good oral health."

Lack of access to oral health care disproportionately harms people with disabilities and people of color: 62 percent of Medicare enrollees under age 65, 68 percent of Black Medicare enrollees, and 61 percent of Hispanic Medicare enrollees did not see a dentist in the last year.[7] People of color and those with disabilities are particularly vulnerable to serious health conditions exacerbated by poor oral health, such as diabetes and cardiovascular disease. Pediatric dentists often face challenges in transitioning patients with disabilities to an adult dentist after the age of 18. Unfortunately, many general dentists are not comfortable in treating patients with physical or developmental disabilities. As a result, many individuals with disabilities are forced to seek costly dental services in emergency departments. The profession is working to address these serious issues via improved education and training in dental schools and in residency programs.

Most people with disabilities have health coverage through Medicare (without a robust dental benefit) or Medicaid (regardless of income level).[8,9] For those who live in States without a comprehensive dental benefit, their options for dental care are limited. This is one significant reason why the AAPD has endorsed S. 570, the Dental Medicaid Benefit Act of 2023, and strongly supports Senator Cardin's leadership to establish a required adult dental Medicaid benefit.[10] The AAPD encourages Senator Cardin to press on Senate leadership to advance this legislation in the 118th Congress.

Some patients with disabilities are especially vulnerable to dental disease because their condition makes in-home preventive care more challenging in addition to other medications and medical interventions that might have a negative impact on oral health. In cases of severe dental disease when a patient may not tolerate care in a routine dental setting, comprehensive restorative dental care in a surgical environment (*i.e.,* a dental case in a hospital operating room or an ambulatory surgical center [ASC]) may be indicated. Unfortunately, access to care in these settings has

---

[5] Millions of Children May Lose Medicaid: What Can Be Done to Help Prevent Them from Becoming Uninsured? Georgetown University Center for Children and Families. February 2022, *https://ccf.georgetown.edu/2022/02/17/millions-of-children-may-lose-medicaid-what-can-be-done-to-help-prevent-them-from-becoming-uninsured/*.

[6] Medicaid Unwinding: Bumpy Ride Ahead—What to Know for Your Patients and Your Practice (page 34). *Pediatric Dentistry Today.* May 2023, *https://www.aapd.org/globalassets/2023maypdt.online.pdf*.

[7] Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries. KFF. March 2019, *https://www.kff.org/medicare/issue-brief/drilling-down-on-dental-coverage-and-costs-for-medicare-beneficiaries/*.

[8] Medicaid Oral Health Coverage for Adults with Intellectual and Developmental Disabilities—A Fiscal Analysis. National Council on Disability. March 2022, *https://ncd.gov/publications/2022/medicaid-oral-health-coverage-adults-IDD*.

[9] People with Disabilities Are at Risk of Losing Medicaid Coverage Without the ACA Expansion. KFF. November 2020, *https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion/*.

[10] S. 570—Medicaid Dental Benefit Act of 2023, *https://www.congress.gov/bill/118th-congress/senate-bill/570?*.

been a significant challenge for many years, exacerbated by the COVID–19 pandemic. Hospitals and ASCs forgo dental cases due to historically low Medicare and Medicaid payment rates for dental surgical services compared to other surgical procedures. Fortunately, CMS recently adopted a new Medicare HCPCS code for dental rehabilitation; it was applied to hospital settings under Medicare in 2023 and is currently being proposed to apply to ASCs starting in 2024. However, Congress needs to ensure implementation adequately recognizes the services and costs involved in providing such care in these settings. Further, CMS should encourage State Medicaid programs to adopt this new code and appropriate funding for these services in Medicaid.

Another area of pressing concern is oral health access and oral health disparities in rural communities. Children living in rural communities tend to have poorer oral health outcomes than their peers living in urban or suburban areas.[11] Some of the contributing factors include dentist and dentist staff (hygienists and assistants) workforce shortages and lack of oral health literacy.

The AAPD supports the Oral Health Literacy and Awareness Act (S. 403/H.R. 994), which would prioritize oral health promotion and disease prevention programs targeting populations with specific oral health needs, including low-income individuals, racial and ethnic minorities, and individuals with disabilities. The AADP also supports the Healthcare Extension and Accessibility for Developmentally Disabled and Underserved Population (HEADs Up) Act which aims to expand and enhance health-care services, including dental care, for individuals with developmental disabilities. The legislation seeks to include individuals with developmental disabilities within special medically underserved populations, ensuring their specific health-care needs are recognized.

Additionally, contributing to the lack of access for dental services for certain populations is the problem of health plans systematically and routinely denying claims and appeals for medically necessary procedures related to congenital abnormalities or birth defects. These conditions affect how individuals develop, function, or look, often for the rest of their lives. Intensive dental and oral care for individuals with congenital abnormalities is a standard of care in dentistry, and without insurance coverage families bear the burden of how to pay for their child's treatment or procedures that are required to repair function—and to help kids enjoy happier, healthier childhoods.

Of those 120,000 children born annually in the U.S. with birth defects, approximately 40,000 require reconstructive surgery. While this legislative effort falls outside the jurisdiction of the Finance Committee, the AAPD encourages Congress to reintroduce the Everlasting Smiles Act [of 2023] and work to advance and address this issue in this Congress.

Question. At the beginning of this year, Maryland's Medicaid program launched a comprehensive adult dental benefit.

What, if any, lessons have been learned from States that have offered or are starting to offer comprehensive dental services to adults on Medicaid regarding the effect on health disparities for minority or other underserved populations at greatest risk of lack of access to oral health care?

Answer. The financial lesson learned is that for a small cost to the State for dental care, a large financial savings will result when the proper dental therapeutic treatment is provided. Access to covered oral health care relieves a person of pain and suffering.

Medicaid adult coverage for comprehensive dental care is an absolute necessity in the U.S. As pediatric providers, we are supremely aware of the impact coverage has on parent/caregiver employability, family-wide access to services, and a person's lifetime development. Adults who have coverage have better job prospects and are better able to retain their jobs.[12] Children whose parents have dental coverage are

---

[11] Hidden Crisis: Pediatric Oral Health in Rural America. Ignelzi, M., et al. American Academy of Pediatric Dentistry: Research and Policy Center. 2023, *https://www.aapd.org/globalassets/ruralpediatricoralhealth_aapd_rpc.pdf*.

[12] Oral Health and Well-Being Among Medicaid Adults by Type of Medicaid Dental Benefit. Health Policy Institute, American Dental Association. 2018, *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0518_1.pdf?rev=17671fb131f845d6a3662779c5de2de1&hash=51EC39EA18B6F6981BDFB7795D8E337C*.

more likely to be established with a dental home themselves.[13] When children have dental coverage, they tend to perform better in school, attain higher-paying jobs, and have better overall health as adults.[14]

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The oral health-care workforce is one of the first stops in reducing barriers to oral health care. As we heard during the hearing, there are many existing gaps in the dental workforce that contribute to some of the racial, ethnic, and geographic disparities that we see in access to care. While the oral health workforce has become increasingly diverse, there are still opportunities to achieve greater recruitment of minority oral health professionals. Regardless of insurance status, in 2019 non-Hispanic Black (26.4 percent) and Hispanic (25.3 percent) individuals were less likely to have had a medical and dental visit within the year than non-Hispanic White individuals (43.3 percent). In addition, individuals in rural communities have lower rates of dental care utilization, higher rates of dental caries, and fewer dentists per capita when compared to individuals in urban communities. Rural seniors are also less likely to have visited a dentist in the past year and rural children are less likely to receive preventive dental care than their urban counterparts.

What are the existing barriers to achieving a diverse oral health care workforce?

Answer. The HRSA title VII pediatric dentistry residency program recruits dentists from a pool of candidates limited to college graduates who have also completed dental school (usually an additional 4 years); the demographics of this group do not match that of the general population.

Question. How can Congress work towards better incentivizing a more diverse oral health-care workforce?

Answer. In response to the challenges noted above, Congress has invested in HRSA title VII primary care oral health programs, which have supported expansion, improvement, and diversification of pediatric dental residency training. This program allows for residents to treat patients in community-based settings outside of a dental school clinic or hospital and gain an appreciation for the access challenges due to social determinants of health. While outside of the Finance Committee's jurisdiction, we ask that Senators maintain their support for the title VII pediatric dental residency training program.

The HRSA title VII program also supports dental faculty loan repayment, which is important to recruiting and retaining pediatric dental faculty (as dental graduates faces tremendously high student loan debt). This helps ensure diverse faculty mentors are in place to support diverse trainees. To make this program even more effective, Congress should act on legislation introduced in the last Congress by Senators Cardin and Wicker to make such repayments non-taxable to faculty recipients.[15]

The AAPD also supports H.R. 3843, bipartisan legislation that has passed out of the House committee of jurisdiction to reauthorize the Action for Dental Health program for 5 years (2024–28). This legislation would direct Federal funding to State and local organizations through HRSA's oral health workforce grant program.[16] Workforce shortages persist in dentistry, and this reauthorization is essential to supporting the creation of a workforce pipeline to support underserved communities.

---

[13] The Association Between Medicaid Adult Dental Coverage and Children's Oral Health. Lipton, B.J., et al. *Health Affairs*. November 2021, *https://pubmed.ncbi.nlm.nih.gov/34724426/*.

[14] Children's dental service use reflects their parents' dental service experience and insurance. Edelstein, B.L., et al. *JADA*. December 2020, *https://pubmed.ncbi.nlm.nih.gov/33228886/*.

[15] S. 2172—The Dental Loan Repayment Assistance Act of 2023; Cardin and Wicker Urge Loan Forgiveness to Recruit More Dentists and Dental Hygiene Faculty, June 2023, *https://www.cardin.senate.gov/press-releases/cardin-and-wicker-urge-loan-forgiveness-to-recruit-more-dentists-and-dental-hygiene-faculty/*.

[16] H.R. 3843—Action for Dental Health Act of 2023, *https://www.congress.gov/bill/118th-congress/house-bill/3843*.

PREPARED STATEMENT OF HON. BENJAMIN L. CARDIN,
A U.S. SENATOR FROM MARYLAND

Let me welcome everyone to the first meeting of the Subcommittee on Health Care of the Senate Finance Committee of this Congress. I want to thank Senator Wyden and Senator Crapo for their cooperation in the establishment of the subcommittee, and our ability to hold hearings.

Senator Daines, I want to thank you for your help and cooperation. I look forward to working with you. We have, obviously, a very important agenda, and I hope that the subcommittee will be able to do some oversight as to some of the issues that are pretty pressing in our health-care system, during this Congress. I look forward to working with you, and I am very pleased that Senator Stabenow is here. Senator Stabenow has been one of the great leaders on health care in the United States Senate, and she served with great distinction as chair of this subcommittee. So, I thank her for her help. I know of no subject that she has been more active in than on oral health care. She's been one of our great leaders in this area of oral health care.

So, today's subject is the oral health-care crisis: the need to address disparities. Disparities in our health-care system are well documented—and the impact they have in regards to vulnerable communities. With the passage of the Affordable Care Act, we elevated the Institute for Minority Health and Health Disparities as a full institute under the NIH, and they have documented the disparities based upon income: lower-income communities do not have the same health-care providers in their communities as we see in other communities. They've documented it in rural America, where again there are not as many health-care providers. We've documented disparities based on race and ethnicity, because again, there are not as many providers in regards to the workforce. So we have documented a lot of the reasons for disparities in our health-care system, and they are very prevalent, the disparities, as it relates to oral health care.

It really came home to me when I was first elected to the United States Senate in 2007. Many have heard me talk about Deamonte Driver, but I will mention him one more time. Deamonte Driver was a 12-year-old who lived in Prince George's County, MD, about 7 miles from here. He had a tooth problem. His mom tried to get him help but could not find a dentist to take care of his needs. She tried several times but was unable to get any help. She fell through the cracks; she wasn't in the Medicaid system at the time; there were some eligibility issues; she didn't have any reimbursement. Deamonte ultimately became very sick and was rushed to the hospital; he had an impacted tooth. He went through two operations, and what would have initially cost $80 for a tooth extraction ended up costing hundreds of thousands of dollars, and tragically Deamonte Driver lost his life. So that really struck home: a person in the community that I represented, that we could have that kind of outcome. It led to some changes in health-care policy. Working with Senator Stabenow, working with my dear friend Elijah Cummings in the House, we were able to extend pediatric dental, under both the CHIP program and the Affordable Care Act program, so we were able to make some progress, but there are still many gaps today.

Oral health is integral to overall health and well-being. It can make worse an underlying health condition, impacting overall health-care costs. It can impact a person's ability to get a job and be well enough to work. It can impact a person's ability to go to school, impacting the local and national economy. It can impact a person's confidence and ability to enjoy life, or communicate effectively, affecting communities and society overall. Despite the importance of oral health, millions of people in the United States are not getting the care they need.

Former U.S. Surgeon General David Satcher said more than 20 years ago that "you cannot be healthy without oral health." Certainly, we have made progress in improving oral health for children since then, especially for vulnerable children. But for working-age adults and seniors, disparities in oral health outcomes and in access to dental care have widened by income and race. Treating dental care as essential in U.S. health policy—for all ages, not just children—is the only way to address these disparities.

The oral health crisis is costly, and taxpayers are paying for it: through worse outcomes for people with diabetes or heart disease, worse pregnancy outcomes, and through emergency room visits. We are paying more in our health-care system as a result of these disparities. One study found that the U.S. could save $22.8 billion annually by improving oral health care.

This is not a partisan issue. During the Trump administration, the U.S. Surgeon General and NIH began working on the report that became "Oral Health in America: Advances and Challenges," which was released by the Biden administration in 2021. This was a follow-up to the landmark report from 2000, "Oral Health in America: A Report of the Surgeon General," which provided a comprehensive look at the importance of oral health and the disparities in the United States.

I have been pleased to work with the Biden administration to advance a number of oral health priorities, including the historic appointment of Dr. Natalia Chalmers to be the Centers for Medicare and Medicaid Services' Chief Dental Officer. That position lay vacant for many years. We finally got it filled, and we are very pleased that we have that position, in order to put a focus within HHS on oral health care.

And at the beginning of this year, Maryland Medicaid began covering adults. However, 16 percent of Maryland residents over 65 years of age and older—approximately 626,000 people in my State—and more than 70 percent of seniors in Maryland do not have dental insurance. We have gaps that we need to deal with.

To echo former U.S. Surgeon General C. Everett Koop, "there is no health without oral health." Adequate access to oral health is essential to preventing tragedies like the passing of Deamonte Driver from ever happening again. I hope we can work together to try to narrow the disparity gaps that we have and find ways we can deal with the health-care crisis.

PREPARED STATEMENT OF HON. STEVE DAINES,
A U.S. SENATOR FROM MONTANA

Thank you, Mr. Chairman. I'm glad to be with you hosting our first subcommittee hearing of this Congress.

It is also a real pleasure to be joined today by Mr. Jon Forte from RiverStone Health in Billings, MT. We'll have a more formal introduction shortly, but thank you for being here, Jon. Glad you're with us.

Oral health care is critically important—both for its own sake, and in relation to our overall health and well-being. A number of conditions can be associated with oral health implications, including diabetes, cardiovascular disease, arthritis, and Alzheimer's disease. There are also studies indicating links between mental health and oral health, as some of the first signs of mental health stressors can manifest in the mouth.

As we continue to look for holistic approaches to caring for the mind and the body, oral health has a distinctive role to play. Over the years, there has been much bipartisan success in providing access to dental health care, such as through the Children's Health Insurance Program and Medicare Advantage. I am proud of these accomplishments and what these programs have achieved, but there are still some challenges to be addressed.

When we consider disparities in access to oral health care, perhaps the greatest barrier for Montanans and Americans in rural States is geography. In Montana, people often have to drive great distances to receive any kind of health care, especially to see a dentist or dental specialist. In part, this is because of how large Montana and the West are, but also because of the significant shortages we are experiencing in the health-care workforce—shortages which are disproportionately felt in more rural areas of the country.

Just earlier this month, I sat down with members of the Montana Dental Association, and their number one concern was workforce, subsequently followed by housing. Housing is a top issue for their staff members and dental care teams—one provider shared that he had never heard his team talk so much about affording a place to live.

Another concern is the mental health of our dental community. We are all aware of the mental health crisis in our country today and, of course, our health-care professionals are not immune from experiencing this crisis themselves—especially in Montana, where suicide is sadly taking too many lives.

Like physicians, the dental profession is linked to high levels of stress, depression, anxiety, and burnout—and dentists can have additionally distinct challenges as both providers and small business owners. The COVID pandemic exacerbated these struggles, contributing to the workforce shortages we are experiencing today as we move beyond the pandemic.

It is my priority to ensure that our dental providers, and all who serve in our health-care workforce, have the resources they need to care for their mental wellness. These hardships are realities for Montanans and health-care professionals across the country, and it serves as a reminder that we must also think about holistic solutions to these problems.

I also want to highlight one of the most important approaches to facilitating comprehensive, integrated health care, and that is through the work of our community health centers. Our health centers serve as points of care for millions of patients across the country, many of whom are uninsured, living in poverty, and located in rural communities. The number of community health centers that offer dental services has grown by 60 percent in the last 10 years, and in Montana, we are fortunate to have 93 percent of our health centers offering dental services onsite.

I'm grateful for all the work our health centers do to provide access to dental care and address disparities throughout Montana and the country.

I want to acknowledge Chairman Cardin's long-time leadership on this particular area of health care, and also thank the witnesses for being here today and offering their expertise on the subject.

I'm looking forward to our discussion today.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF CHERAE FARMER-DIXON, D.D.S., MSPH, MBA, FACD, FICD, DEAN AND PROFESSOR, SCHOOL OF DENTISTRY, MEHARRY MEDICAL COLLEGE

There has been significant progress in the improvement of general health and well-being of the United States population over the past century.[1–9] Due to this, most Americans are living longer and healthier lives. Mortality rates have been reduced as health care continues to improve.

In this time, there have been significant breakthroughs in diagnosis and treatment of oral diseases.[10] These oral health innovations help most Americans live better lives; however, not all have benefited. While we have made great progress, it has not been equitable.

Many Americans still experience chronic and treatable pain and illness with complications that devastate overall health, well-being, and have considerable financial and social ramifications. The silent epidemic of oral diseases affects our most vulnerable populations: poor children, the elderly, and members of racial and ethnic minority groups.[11]

Oral health and disease are associated with cardiovascular disease, immune disorders, microbial infections and cancers. New research points to the associations between chronic oral infections and heart and lung diseases, stroke, low-birth weight and premature births. Associations between periodontal (gum) disease and diabetes have also long been noted.[12, 13]

ORAL HEALTH DISPARITIES

Dental maladies exist across the lifespan and disproportionately effect vulnerable populations. There are common dental anomalies found in infants, children, adolescents, pregnant women and the elderly. Caries (cavities) continue to be one of the most common chronic diseases in U.S. children. When left untreated, pain and infection can develop and lead to more oral health issues. Gum disease and tooth loss disproportionately impact the overall health of minority populations.

Pregnant women with poor oral health are more likely to deliver infants with low birth weights. Infants experience poor oral health and preventable diseases, like baby bottle cavities, due to lack of knowledge, limited access to care, and inadequate resources. Children with poor oral health miss more school and receive lower grades.[14] Research shows that 17 percent of children, aged 2 to 5 years old, living in low-income households have untreated cavities—three times the amount found in children from higher-income households.[15] Childhood oral health issues persist throughout adolescence and into adulthood when left untreated.

Hormonal changes during puberty and adolescence may in some cases attribute to an increased incidence of cavities and gum disease. In children ages 12 to 19, 23 percent of children from low-income families have untreated cavities twice that of children from higher-income households.[15]

The adult population is living longer and many experience oral health problems such as tooth decay, tooth loss, gum disease, xerostomia (dry mouth), chronic disease, oral cancer and pre-cancer conditions. These problems may cause pain, issues with chewing and eating and difficulty with smiling and communication, as well as have an impact on the lifespan.[13] Among working-age U.S. adults, over 40 percent of low-income and non-Hispanic Black adults have untreated tooth decay.[16] Adults with less than a high school education are almost three times as likely to have untreated cavities as adults with at least some college education.[15] About 40 percent of adults with low-income or no private health insurance have untreated cavities. Low-income or uninsured adults are twice as likely to have one to three untreated cavities and three times as likely to have four or more untreated cavities as adults with higher incomes or private insurance.[16]

Most of us will experience dental disease, especially as we age. Nearly all adults (96 percent) aged 65 years or older have had a cavity; and one in five have untreated tooth decay.[13, 17] Total tooth loss is experienced in nearly one in five adults aged 65 or older. Complete tooth loss is twice as prevalent among adults aged 75 and older (26 percent) compared with adults aged 65–74 (13 percent).[13, 17] A high percentage of older adults have gum disease. About two in three, or 68 percent, of adults aged 65 years or older have gum disease.[13, 18] The prevalence of disease, however, varies vastly among race and ethnic groups. For example, 46 percent of African American adults have decay as compared to 27 percent of adults nationwide.[13, 19]

ACCESS TO CARE

Low-income populations, across all ages, experience the lowest access to oral health care.[20] The 2020 National Institutes of Health (NIH) report, "Oral Health in America: Advances and Challenges," generated a call to action by the National Institute of Dental and Craniofacial Research (NIDCR) director, the National Institutes of Health director, and the U.S. Surgeon General to ensure oral health for all.[2, 21]

The newly issued report provides a comprehensive snapshot of oral health in America, including an examination of oral health across the lifespan and a look at the impact the issue has on communities and the economy. Major take-aways from the report include:

- Group disparities pertaining to oral health, identified 20 years ago, have not been adequately addressed. Greater efforts are needed to tackle the social determinants that create these inequities and the systemic biases that perpetuate them.
- Healthy behaviors can improve and maintain oral health, but these behaviors are influenced by social and economic conditions.
- Oral and medical conditions often share common risk factors. Oral health treatment can improve other health conditions and individual health overall.
- Substance misuse and mental health conditions negatively affect the oral health of many.[22]

The Healthy People 2020 Report demonstrated that oral health is essential to our overall health. The report also highlighted that those who need dental care are the least likely to have access. These individuals disproportionately are low-income, live in poverty, and are most likely representative of minority populations. Many reside in geographically isolated areas with reduced access to dentists and Medicaid providers.[23] Rural areas often have inadequate public transportation systems, barring many from access to dentists.[23, 24] Rural populations also have a higher prevalence of cavities and tooth loss and a lower degree of private dental insurance combined with limited access to public dental services.[25, 26] As a result, those who need dental care the most are the least likely to receive it.[20]

DENTAL WORKFORCE

The U.S. population continues to diversify with increases in the Hispanic and Asian populations, while Black population remains stable. This trend is predicted to continue along with other population demographics over the next 20 years. The current dental workforce does not reflect the diversity that is demonstrated throughout the United States. Blacks make up an estimated 12.4 percent of the U.S. population, and approximately only 4 percent of the dental workforce. Hispanics make up an estimated 18 percent of the U.S. population and approximately 6 percent of the dental workforce. The dentist workforce consistently skews more Asian and White and is underrepresented significantly by Hispanic and Black dentists[27] (Figure 1).

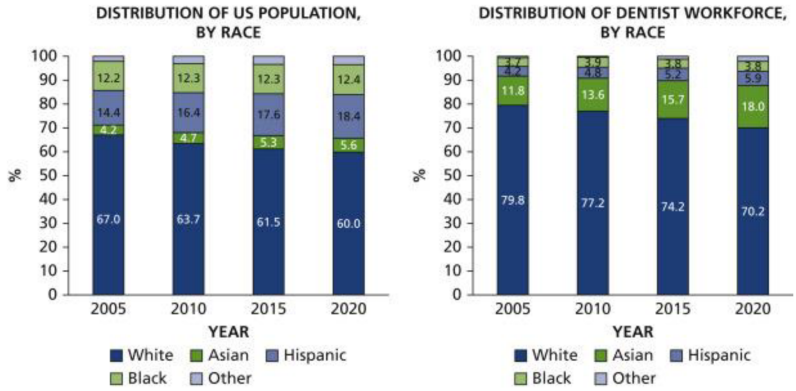


Figure 1: Diversity and trends of the general population compared with the dentist workforce, by race, 2005 through 2020. Source: American Dental Association Health Policy Institute.

Greater diversity in the dental workforce is necessary to effectively address the needs of the population. The Health Resources and Services Administration (HRSA) estimates that there is a current shortage of 10,877 dentists in the United States.[28] Several dental schools that have opened in recent years cite insufficient supply of dentists as a key reason as to why the U.S. needs more dental school graduates.[29, 30, 31] These dental school expansions, however, have yet to demonstrate a significant increase in producing minority dentists.

Twenty-seven percent of the practicing African American dentists in the U.S. are graduates of Meharry Medical College. The burden of increasing diversity cannot rest solely on the two HBCU dental schools (Meharry and Howard). There must be continued intentional efforts within the dental education that includes collaboration with schools at all levels, beginning in Pre-K and Kindergarten as well as working with community organizations, churches, health care and other professional organizations and corporations. There must be a concerted group effort to make a significant impact.

A recent report by the Oral Health Workforce Research Center found that "improving the racial and ethnic diversity of the nation's dentists is critical in efforts to reduce disparities in access to care and health outcomes and to better address the oral health needs of an increasingly diverse U.S. population." Research shows that patients are more comfortable receiving care from a provider of their own race.

Studies have also determined that non-white dentists care for a disproportionate number of at-risk patients in minority and underserved communities. Researchers have found that 53 percent of clinically active Black dentists reported primarily treating underserved patients at their primary practice, and another study concluded that "the Hispanic/Latino (H/L) dentist workforce is a critical component of our dental delivery system and is shown to contribute to improved access for H/L populations and underserved populations."[32]

Increasing racial diversity within the oral health care workforce is therefore imperative for eliminating access barriers, increasing utilization, and improving outcomes.

Strategies to improve and help eliminate oral health disparities collectively include:

1. Improving access to care through incentives for rural and inner-city workspaces;
2. Increasing the diversity of the workforce;
3. Greater interprofessional training and collaboration; and
4. Support of federal programs that increase maintain and/or enhance programs that impact health care delivery such as loan repayment programs and federal renumeration.

If we want to adequately combat and eliminate oral health disparities, we must meet communities where they are.

REFERENCES

1. U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research. Oral Health in America: A Report of the Surgeon General. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research; 2000.
2. U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research. Oral Health in America: Advances and Challenges. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research; 2021.
3. Pihlstrom B.L., Highlights of America's scientific contributions to dentistry: 150 years and still counting, *J Am Dent Assoc.* 2009;140(Suppl 1):4S–6S. doi:10.14219/jada.archive.2009.0352.
4. Gutmann J.L., The evolution of America's scientific advancements in dentistry in the past 150 years, *J Am Dent Assoc.* 2009;140(Suppl 1):8S–15S. doi:10.14219/jada.archive.2009.0354.
5. Snead M.L., Slavkin H.C., Science is the fuel for the engine of technology and clinical practice, *J Am Dent Assoc.* 2009;140(Suppl 1):17S–24S. doi:10.14219/jada.archive.2009.0351.
6. Zero D.T., Fontana M., Martínez-Mier E.A., et al. The biology, prevention, diagnosis and treatment of dental caries: Scientific advances in the United States, *J Am Dent Assoc.* 2009;140(Suppl 1):25S–34S. doi:10.14219/jada.archive.2009.0355.
7. Armitage G.C., Robertson P.B., The biology, prevention, diagnosis and treatment of periodontal diseases: Scientific advances in the United States, *J Am Dent Assoc.* 2009;140(Suppl 1):36S–43S. doi:10.14219/jada.archive.2009.0356.
8. Garcia I., Tabak L.A., A view of the future: dentistry and oral health in America, *J Am Dent Assoc.* 2009;140(Suppl1):44S–48S. doi:10.14219/jada.archive.2009.0357.
9. Satcher D., My Quest for Health Equity: Notes on Learning While Leading, Baltimore: Johns Hopkins University Press; 2020, available from: *https://muse.jhu.edu/book/76605,* accessed September 24, 2022.
10. Slavkin, H., Dubois, P.A., Dushanka, K., Fucillo, R., Science Informed Health Policies for Oral and Systemic Health, *Journal of Healthcare Leadership,* March 2023.
11. U.S. General Accounting Office (GAO), Oral health in low-income populations, GAO/HEHS–00–72, April 2000.
12. 2000 Surgeon General's Report on Oral Health in America, National Institute of Dental and Craniofacial Research *(nih.gov).*
13. Farmer-Dixon, C., Thompson, M.F., Barbour, J., Health Disparities in Oral Health, *Oral Health and Aging,* Springer 2022.
14. Children's Oral Health, Basics, Division of Oral Health, CDC.
15. Centers for Disease Control and Prevention, Oral Health Surveillance Report: Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999–2004 to 2011–2016, Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019, *https://www.cdc.gov/oralhealth/publications/OHSR-2019-index.html*.
16. Williams S., Wei L., Griffin S.O., Thornton-Evans G., Untreated caries among U.S. working-aged adults and association with reporting need for oral health care, 2021;152(1):55–64, doi.org/10.1016/j.adaj.2020.09.019external icon.
17. Dye B.A., Thornton-Evans G., Xianfen L., Iafolla T.J., Dental Caries and Tooth Loss in Adults in the United States, 2011–2012, NCHS Data Brief, no 197. Hyattsville, MD: National Center for Health Statistics; 2015.
18. Eke, P.I., Dye, B.A., Wei, L., et al. Update on prevalence of periodontitis in adults in the United States: NHANES 2009 to 2012, *J of Periodontol,* 2015 May; 86(5):611–622. doi: 10.1902/jop.2015.140520.
19. (USDHHS, 2000a).
20. U.S. Senate Committee on Health, Education, Labor, and Pensions, Subcommittee on Primary Health and Aging [Internet], Washington, DC: Government Printing Office; 2012 February 29. Dental crisis in America: The need to expand access. [cited July 18, 2015]; [14 screens], available from: *http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf.*

21. D'Souza, R.N., Collins, F.S., Murthy, V.H., Oral health for all—Realizing the promise of science. *N Engl J Med.* 2022;386(9):809–811. PMID: 35213102. doi:10.1056/NEJMp2118478.
22. National Institutes of Health Report details 20 years of advances and challenges of Americans' oral health, available from: *http://medicalexpress.com/news/2021-12years-advances-oral-health.html.*
23. Skillman, S.M., Doescher, M.P., Mouradian, W.E., Brunson, D.K., The challenge to delivering oral health services in rural America. *J Public Health Dent* [Internet], June 23, 2010 [cited July 18, 2015]; 70(Suppl):S49–S57.
24. National Organization of State Offices of Rural Health [Internet], Michigan: National Organization of State Offices of Rural Health; c2006–2015, Oral health in rural America [cited August 27, 2015]; [4 screens], available from: *https://nosorh.org/wp-content/uploads/2013/08/Oral-Health-Fact-Sheet-and-Resources.pdf.*
25. U.S. Department of Health and Human Services, Health Resources and Service Administration [Internet], Washington DC: Government Printing Office; June 19, 2014, Shortage designation: Health professional shortage areas and medically underserved areas/populations [cited August 25, 2015]; [1 screen]. Available from: *http://www.hrsa.gov/shortage/*.
26. U.S. Department of Health and Human Services, Health Resources and Service Administration [Internet]. Washington DC: Government Printing Office. Oral health workforce [cited August 25, 2015]; [1 screen]. Available from: *http://www.hrsa.gov/publichealth/clinical/oralhealth/workforce.html.*
27. J. Tim Wright, D.D.S., MS, Marko Vujicic, Ph.D., Sylvia Frazier-Bowers, D.D.S., Ph.D., Elevating dentistry through diversity. *The Journal of the American Dental Association,* Volume 152 Issue 4 Pages 253–255 (April 2021), DOI: 10.1016/j.adaj.2021.02.003.
28. Bradley Munson, B.A., Marko Vujicic, Ph.D. Projected Supply of Dentists in the United States, 2020–2040. American Dental Association Health Policy Institute.
29. Touro College of Dental Medicine. Touro unveils New York State's first new dental school in nearly 50 years, New York Medical College, September 28, 2016, available from: *https://www.nymc.edu/news-and-events/press-room/2016-press-archives/touro-unveils-states-first-new-dental-school-in-nearly-50-years.php,* accessed March 17, 2021.
30. Texas Tech University Health Sciences Center El Paso, $25 million gift establishes new dental school in El Paso, *Tech View,* September 6, 2016, available from: *http://eptechview.ttuhsc.edu/ttuhsc-el-paso/25-million-gift-establishesnew-dental-school-in-el-paso/*, accessed March 17, 2021.
31. A.T. Still University, Missouri School of Dentistry and Oral Health, About, available from: *https://www.atsu.edu/stlcenter/about.html,* accessed March 17, 2021.
32. Brian, Z., Diversity in the Workforce: An Opportunity for Change, May 10, 2021, available from: *https://oralhealthnc.org/diversity-in-the-workforce.*

QUESTIONS SUBMITTED FOR THE RECORD TO CHERAE FARMER-DIXON, D.D.S., MSPH, MBA, FACD, FICD

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. COVID–19 upended daily life and continues to impact our communities and our health-care system today. What are some lessons learned from the pandemic about oral health care and access to oral health care that the committee should be aware of?

Answer. The pandemic highlighted disparities in oral health care and the lack but need for striving to achieve health equity. Lessons learned include the following:

- **Dental office limitations.**—Limitations of the dental office to accommodate infections created by air-borne pathogens resulted in many being closed and providing only emergency services. Persons with limited or no access to care suffered the greatest burden. Furthermore, there was a greater negative impact on the oral status of individuals who are already the most vulnerable: poor and underserved communities as well as uninsured individuals. This created the opportunity to expand safety measures for dental offices as a result of the increased risks with air-borne pathogens. Air filtration devices and filtration mechanisms were incorporated to increase safety and decrease risks.

The pandemic also created the opportunity to examine the control and regulatory limitations placed on oral health practitioners and dental offices so that they could reopen.

- **Immunizations with dentists/oral health care professionals.**—There was a greater need for immunizations/vaccines. Licensed dentists can and should be authorized universally to give certain immunizations, thus creating more opportunities for them to have a greater role in vaccines and infection control as well as serve as an additional resource to offer health guidance to the population.
- **An increased need for diversity in the oral health-care workforce.**—There is a need to increase diversity in the workforce and therefore to focus on initiatives that will support and have the potential to achieve these outcomes. Studies have demonstrated that there are better health outcomes in communities where populations have individuals who look like them. Pipeline programs such as the Health Career Opportunity Program (HCOP) that is offered through the Health Resources and Services Administration have been a great vehicle for introducing, recruiting, and increasing the number of minority oral health care professionals. In addition, financial resources through the National Health Service Corp as well as title VII funding initiatives such as the Faculty Loan Repayment Program have also served as vehicles to recruit and retain individuals in underserved areas. These programs help to offset some of the loan indebtedness associated with dental education which averages around $350,000. This does not include debt that individuals also have accumulated from their undergraduate training.
- **Increased Medicaid renumeration to attract more providers.**—Many dentists do not choose to participate in Medicaid or Medicare programs because the renumeration rate is significantly lower than traditional insurances. With the high costs of dental overhead as well as loan indebtedness, it creates a financial burden and makes it less attractive to become a provider. This creates an opportunity to increase the renumeration for Medicaid and Medicare, making it more attractive and amenable for dentists to participate.
- **A need for adult dental coverage in all States along with the understanding of how critical oral health is to overall health.**—Many populations can not afford private dental insurance. In addition, they may be eligible and have Medicaid and/or Medicare. However, if their State does not offer adult dental coverage, this negatively impacts their ability to afford dental treatment, resulting in no care or limited care for emergencies only. These emergencies typically result in loss of teeth. Furthermore, conditions can be exacerbated in patients with other underlying health issues such as diabetes and/or heart disease. Well documented data has shown correlations between oral conditions such as periodontal disease and heart disease, diabetes and Alzheimer's. Therefore, there is a greater need for oral health care to be engrained more in discussion and treatment of overall health care through interprofessional collaboration (medical, dental, social work, allied health, etc.) for improved overall health outcomes.

Question. As States resume redetermining who is eligible for Medicaid this Spring, we know that many people will lose their Medicaid coverage. Some will lose their coverage even if they are still eligible for procedural reasons.

How will these changes impact access to oral health care?

Answer. Individuals who will lose coverage will no longer have access to receive routine oral health care. Individuals who are traditionally Medicaid recipients cannot afford the out-of-pocket costs of routine dental care, even when it is at a reduced cost such as through services provided at some Federally Qualified Health Centers and State health departments. In addition, if these individuals have underlying conditions such as heart disease or diabetes, their oral health condition can be compromised. When services are sought, it is typically for emergency care, usually resulting in extractions to eliminate pain.

Routine care is essential to maintain a healthy oral cavity and aid in eliminating potential dental disease. Data has demonstrated that there is an association between oral and systemic health. Furthermore, disease that is present in the mouth has been correlated with cardiovascular disease, diabetes, and Alzheimer's. The lack of Medicaid coverage for routine care can essentially result in sicker patients causing increased costs in medical care that will potentially be needed.

Question. Oral health is integral to overall health. Older adults and people with disabilities have some of the worst access to oral health coverage and oral health care, with particular inequities in access for people of color. For example, prior to the pandemic, 7 out of 10 Black Medicare beneficiaries and 6 out of 10 Hispanic beneficiaries reported they haven't seen a dentist within the past year.

Can you speak more about how older adults and people with disabilities are affected by a lack of affordable or accessible oral health coverage, particularly since oral health can impact other underlying conditions?

Answer. Medicare does not cover routine dental care and covers only limited care for people with disabilities. A large percentage of these individuals do not have separate and/or private dental insurance that would cover some of the dental expenses. As a result, they are unable to afford dental coverage and go without and only seek care on an emergency basis.

In cases where there is limited coverage such as in people with disabilities, the challenge of accessibility exists as a result of the unavailability or limited availability of providers who will accept their Medicare coverage. There have been instances, particularly in rural and remote areas, where individuals have to travel as far as 60–100 miles to seek treatment from a provider who will accept the low Medicare reimbursement rate.

Medicare renumeration is less than traditional insurance reimbursement for the same dental service. For various reasons, some practitioners choose not to participate in the Medicare and Medicaid programs, resulting in limited access to care for those patients who may have benefits through these government agencies.

Question. At the beginning of this year, Maryland's Medicaid program launched a comprehensive adult dental benefit.

What, if any, lessons have been learned from States that have offered or are starting to offer comprehensive dental services to adults on Medicaid regarding the effect on health disparities for minority or other underserved populations at greatest risk of lack of access to oral health care?

Answer. Medicaid expansion to include comprehensive dental care for adults provides increased affordability of dental care for populations who are some of the most vulnerable. Low income populations and people of color have higher incidences of caries as underlying conditions such as heart disease, diabetes, etc. More importantly, they are routinely the individuals who are most in need of care and have the least access to care.

Comprehensive dental services for adults will serve to decrease the health disparities gap for minority and other underserved populations by providing them access to care and affordability of care.

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The oral health-care workforce is one of the first stops in reducing barriers to oral health care. As we heard during the hearing, there are many existing gaps in the dental workforce that contribute to some of the racial, ethnic, and geographic disparities that we see in access to care. While the oral health workforce has become increasingly diverse, there are still opportunities to achieve greater recruitment of minority oral health professionals. Regardless of insurance status, in 2019 non-Hispanic Black (26.4 percent) and Hispanic (25.3 percent) individuals were less likely to have had a medical and dental visit within the year than non-Hispanic White individuals (43.3 percent). In addition, individuals in rural communities have lower rates of dental care utilization, higher rates of dental caries, and fewer dentists per capita when compared to individuals in urban communities. Rural seniors are also less likely to have visited a dentist in the past year and rural children are less likely to receive preventive dental care than their urban counterparts.

What are the existing barriers to achieving a diverse oral health-care workforce?

Answer. Several underlying issues barricade the diversification of the dental workforce; however, limited awareness, lack of minority recruitment, and high costs of dental education stand at the forefront of this uphill battle. Inadequate acknowledgment of oral health care career opportunities and insufficient support for "pipeline programs" deprive racial minorities of vital preparatory information. The implementation of pipeline programs directly influences access to mentorships, scholarships, externships, and several other opportunities. Placing increased funding in

these foundational initiatives with a continued focus on underrepresented communities will help attract the next generation of students to oral health care education and dental careers. Pipeline programs, such as the HCOP has a longstanding track record of serving as an effective minority recruitment tool and assisting in increasing diversity. On a personal note, I was introduced to dentistry when I participated in a summer HCOP program for high school students. As a result of that program, I knew that I wanted to be a dentist and continued on that quest which led to me not only becoming a dentist, but serving as a dental educator and dean of a dental school. Furthermore, the strategic revitalization of dental school recruitment, would proactively reach more diverse pools of applicants and create dental classes that represent the populations that they will serve. This revitalization should include the execution of small changes like intentionally diversifying staff and faculty, integrating intercultural competency into the dental curriculum, and increasing financial assistance and scholarship opportunities. Thus, making dental schools appear more accessible and achievable for potential applicants.

Question. How can Congress work towards better incentivizing a more diverse oral health-care workforce?

Answer. Congress would make the biggest impact by not only continuing to invest in targeted pipeline programs and retention programs but by also increasing funding. Increased funding of the National Health Service Corp to support students while in dental school and post-graduation would help to offset the costs while guaranteeing a commitment to practice in some of the most vulnerable communities where there is the greatest need—rural and inner-city communities.

Increased funding of the Health Careers Opportunity Program that is authorized through the Public Health Service Act will serve to expand programs that serve to introduce minorities and others from disadvantaged backgrounds to health careers. HCOPs provide mentoring, support, and internships in an effort to not only spark their interest but lead them into dental careers, thus diversifying the oral health-care workforce. According to workforce data, an additional 11,000 dentists are needed to serve the population. By providing affordable training, academic enrichment programs, and virtual mentorship and internship programs, student engagement would be consistent throughout their academic careers. Also, creating financial investments, like paid internships and accelerated programs to try to ease the monetary burden. Moreover, investing in the surrounding communities of institutions to encourage local recruitment and increase opportunity accessibility.

PREPARED STATEMENT OF JONATHAN P. FORTE, MHA, FACHE, PRESIDENT AND CEO, RIVERSTONE HEALTH

INTRODUCTION AND BACKGROUND

Chairman Cardin, Ranking Member Daines, and members of the committee, thank you for the opportunity to testify on such a critical issue. My name is Jonathan Forte, and I am the president and CEO at RiverStone Health in Billings, MT. For over 40 years, health, education, leadership, and protection (HELP) have been the foundation of our work.

In our role as the Yellowstone City-County Health Department, we lead public health efforts to protect safety and well-being, as the largest health department in Montana's largest city. We were also one of the first 50 health departments in the Nation to receive Public Health Accreditation. Our Federally Qualified Health Center serves more than 14,000 patients a year, in eight locations across Yellowstone and Carbon Counties. As one of the first Teaching Health Center's in the Nation, we provide high-quality, affordable care to all, regardless of anyone's ability to pay.

Today, I will share my perspective, acquired in various health-care management roles within the Veterans Health Administration (VHA), as a Community Health Center executive and as a public health professional. My career began in Scranton, PA and has always focused on serving underresourced and marginalized populations across Maryland, West Virginia, Washington, DC, North Carolina, and now Montana. Equitable access to oral health care is not simply a rural problem, or an urban problem, it's an American problem impacting families no matter where they live.

My testimony will reflect the experiences of our patients and oral health-care professionals, who serve them, as well as three key elements I believe are essential to providing equitable access to care and alleviating our Nation's oral health crisis:

1. Developing collaborative partnerships and centers of innovation for workforce development, focused on supplying the next generation of oral health professionals.
2. Using lessons learned from America's Community Health Centers to support and incentivize fully integrated and equitable models for oral health delivery.
3. Expanding utilization of mobile health to meet patients where they are, delivering care beyond the four walls of traditional dental offices and infrastructure.

RiverStone Health is one of 1,400 Community Health Center organizations across 14,000 rural and urban communities, serving over 30 million Americans. Health centers are medical and dental homes for people of all ages and walks of life—newborns, seniors, the unhoused, veterans, and agricultural workers. Health centers are problem-solvers, and protectors of public health. We provide equitable access to quality health-care services that individuals would otherwise find unaffordable and unattainable. We look beyond the patient's chart for answers that not only prevent illness but address the environmental and social factors that can make people sick—lack of nutrition, exercise, homelessness, mental health, and addiction.

Montana's 14 Community Health Centers (CHCs) serve 120,000 patients annually, 1 of every 10 Montanans. We operate in one of the largest States with a vast geography and just over a million people.

At RiverStone Health, dental visits account for one quarter of all patient encounters. Unfortunately, 34 percent of those dental visits are for emergency care only, meaning a patient is in pain and needs immediate attention to address infection and/or extract a tooth. The majority of our CHC dental patients have incomes less than $60,000/year for a family of four.

Limited services in rural areas require patients to travel to larger communities for oral health care, but the issue is compounded by a lack of resources everywhere, including the larger communities. In Montana, many private dentists don't perform extractions and many of our patients can't readily access oral surgery centers scattered throughout the State. While Montana's Medicaid expansion in 2016 led to a 28-percent increase in access to dental care, almost 80 percent of Montana counties are designated as oral health professional shortage areas.

Veterans comprise 10 percent of Montana's population, and many veterans suffer due to a lack of oral health access. Only 7 percent of veterans are currently eligible for VA dental care. When the VA MISSION Act of 2018 authorized the VET-Smile program, five of the initial eight dental programs chosen to participate in this pilot program were Federally Qualified Health Centers.

RiverStone Health's dental program treats almost 1,000 veterans annually, many of whom are still not eligible for care through VA programs. If the VET-smile program and veteran eligibility requirements were expanded, Community Health Centers would continue answering the call and partnering with VA to enhance access for veteran dental care across the U.S.

Montana is home to seven federally recognized Tribal communities. The prevalence of tooth decay among Native children is significantly higher than White children—84.0 percent compared to 57.4 percent—and the life span of Native individuals is almost 20 years shorter. Montana's Community Health Centers continually work to build trusted relationships with Tribal partners to recognize and remove barriers to care, while providing culturally competent and equitable health services to their communities.

In providing access to affordable care for people least likely to have it, Community Health Centers significantly reduce unnecessary hospitalizations and ER visits and costs to the American taxpayer. With all the challenges already discussed, Montana's average dental cost per patient is very close to the national average of $655.

DISCUSSION

Community Health Centers are essential to solving our Nation's oral health crisis, and here's why: **America's Community Health Centers develop collaborative partnerships and serve as centers of innovation for workforce development, supplying the next generation of oral health professionals.**

In many small Montana towns across our northern border with Canada, Community Health Centers are often the only access point for oral health care. Due to a lack of access throughout our region, RiverStone Health sees patients from all

around Montana, Central Wyoming, and the Dakotas, with patients frequently driving over 500 miles round-trip to visit a dentist.

RiverStone Health's Dental Director, Joey Verlanic, honestly believes she could see patients 24–7–365 and still have patients to see years later, due to the overwhelming need for oral health care across our region.

Community Health Centers and private dental offices in rural and frontier areas are frequently challenged to recruit oral health professionals including dentists, dental hygienists, and dental assistants. Recruitment for dentists in many frontier communities can take 2 years or more. Recently, a health center in Bozeman was unable to retain a qualified dentist, not because of a lack of candidates, but because housing, even for someone with a strong, professional salary, was unattainable. A lack of staff creates bottlenecks to access and simply compounds the crisis.

We continue innovating and finding new ways to develop our oral health workforce. RiverStone works with Montana's only two accredited Dental Assisting (DA) programs at Great Falls College—MSU and Salish Kootenai College. We also created a new, on the job training program within the dental clinic. The Montana Primary Care Association (MTPCA) and member health centers provide scholarships for dental assistants and other students interested in completing a DA program after committing to employment. Great Falls—MSU also operates the only accredited dental hygienist program in Montana, presenting supply challenges and decreasing our ability to develop qualified oral health support staff. RiverStone Health provides the same scholarship program to hygiene students to encourage entry into this rewarding dental career.

The lack of dental schools in Montana, North and South Dakota, Idaho, and Wyoming adds to workforce development challenges and leads to competition for out-of-State dental students. Continuing to innovate, RiverStone Health hosts 2nd- and 4th-year dental students from the University of Washington Dental School's Regional Initiatives in Dental Education (RIDE) program. More than 70 percent of RIDE graduates go onto practice in rural and underserved areas of the Pacific Northwest.

RiverStone Health and health centers across Montana collaborate with the National Network for Oral Health Access (NNOHA) to continually develop innovative workforce solutions such as a new, entry level Sterilization Tech position. Now focused on attracting individuals with no prior medical or dental experience into the field of oral health care, many of these technicians pursue lasting careers in dental assisting or dental hygiene.

RiverStone Health was the first NYU Langone Dental training site in Montana for Advanced Education in General Dentistry (AEGD), enabling us to attract and retain advanced dental clinicians dedicated to providing oral health care to vulnerable communities. NYU Langone Dental Medicine trains over 400 residents across the United States and serves an estimated 1 million patients across 75 community health centers.

Through our Eastern Montana Area Health Education Center (AHEC), RiverStone Health provides exposure opportunities to students from high schools, community colleges, technical schools, and universities, increasing interest in health professions and recruiting them into clinical support roles.

Using lessons learned from America's Community Health Centers, Congress can support and incentivize fully integrated and equitable models for oral health delivery.

Research demonstrates that interdisciplinary teams (professionals from various disciplines working together in one place) increase efficiency, improve cost-effectiveness, and improve health outcomes. RiverStone Health continues to further integrate primary care, dentistry, and behavioral health across our organization.

RiverStone Health is regularly recognized as a Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). PCMH standards emphasize the use of systematic, patient-centered, coordinated care which support access, communication, and patient involvement. RiverStone Health also earned NCQA's Distinction in Behavioral Health Integration.

Recently, a RiverStone Health dental patient was at an appointment for a tooth extraction. While our dental assistant was preparing the patient for their procedure, the patient expressed a desire to die by suicide. Due to our integrated model of care, and the compassion of our team, the DA immediately requested a warm hand-off

consultation with our behavioral health team. A behavioral health therapist was able to visit the patient immediately after the extraction, while in the dental operatory, to ensure they received appropriate care.

Integrated medical, behavioral, and oral health care saves lives. From a fiscal or quality of life perspective, America can no longer afford a health system that maintains outdated, entrenched silos which frequently separate physical and oral health. Ever since the first dental school was founded in the United States in 1840, dentistry and medicine have been taught as and viewed as two separate professions, but RiverStone Health and other CHCs are working to break these precedents.

As home to the Montana Family Medicine Residency (MFMR) the first graduate medical education program in Montana, we attract and train the next generation of physicians to help meet Montana's shortage of family practice physicians. All MFMR Family Medicine Residents complete a 1-week oral health rotation with dental providers in our integrated health center model.

This competency-based oral health education prepares Family Medicine residents to perform oral health risk assessments and evaluations, preventive interventions, patient education, and interprofessional collaborative practice, including how to make proper referrals for specialty care. Over 65 percent of our MFMR physicians remain in Montana and provide medical care in communities where dental care may not be present. The MFMR oral health program begins building lasting relationships between medical and dental providers, fostering a level of collaboration and respect between physicians and dentists that has not always existed.

RiverStone Health also participates in nationally recognized scientific research with the Rocky Mountain Network of Oral Health (RoMoNOH) focusing on providing primary prevention of dental caries in pregnant women, infants, and children from birth to age 40 months. The program is active in community health centers (CHCs) across Arizona, Colorado, Montana, and Wyoming, studying the integration of oral health care into medical clinics. Further teaching family medicine and primary care providers to apply fluoride treatments and conduct dental screenings during well-child visits or annual physicals. By increasing the collective knowledge of medical providers about oral health, RiverStone Health and others can deliver more complete and equitable oral health care, even outside the dental clinic.

Two years ago, a homeless patient walked into the RiverStone Health Dental Clinic suffering from substance use disorder and painful cavities on almost every tooth. Due to our integrated model of care, this patient has a renewed smile, housing, and is actively making lifestyle changes to improve his overall health and well-being.

Expanding utilization of mobile health to meet patients where they are, Community Health Centers deliver oral health care beyond the four walls of traditional dental offices and infrastructure.

Mobile and portable oral health programs have become incredibly successful across the United States, particularly for school-based locations. According to a 2017 report by the Oral Health Workforce Research Center (OHWRC), more than 750 (44.5 percent) school-based health centers (SBHCs) were sponsored by a Community Health Center.

From Maryland to Montana, mobile units increase access to care outside the four walls of our health centers, schools, and nursing homes. Building and supporting real estate is expensive, but studies have shown mobile clinics return $36 for every $1 invested.

In Montana, Community Health Centers utilize mobile health units to treat farmworkers harvesting sugar beets and cherries and provide school-based oral health screenings and sealants to kids in school. Ag Worker Health and Services and Alluvion Health, currently provide preventive and basic restorative oral health services via mobile units.

When the law becomes effective in 2024, the MOBILE Health Care Act of 2022 will make it easier for health centers to expand utilization of mobile medical, dental, and behavioral health clinics. The MOBILE Act is a significant victory for expanding section 330 grantees' ability to treat more patients and meet them where they are. However, our success is completely dependent on the allocation of continued funding for New Access Point grants. Without New Access Point funding, section 330 grantees cannot take advantage of this positive legislation.

CONCLUSION

I recognize the difficult decisions Congress must make to balance funding levels with the need to maintain our Nation's fiscal health, but medical inflation has outpaced health centers' funding increases since 2015, leading to an actual 9.3-percent decrease in actual funding levels. Decades of research show that Federal investments in health centers reduce overall health spending by expanding access to efficient and effective primary care. Patients who access primary care at health centers show positive health outcomes and reduced use of emergency department and hospital stays.

I appreciate that this budget environment makes additional investments challenging, but health centers are well-positioned to address unmet oral health needs if those resources are allocated. The Health Resources and Services Administration (HRSA) estimates that millions of patients would benefit from access to oral health care at the health centers where they already receive primary care. For example, the National Association of Community Health Centers estimates that an additional investment of $500 million over 5 years would allow health centers to hire more than 3,500 oral health providers and serve more than 5 million additional patients. This level of commitment by Congress would leverage the existing network of care and build on a proven model that saves the health system billions of dollars.

Meeting the needs of the patients we serve and the team that cares for them is what matters most to me as a Community Health Center leader. Doing so requires long-term, sustainable, and predictable funding that enables confidence in our mission and supports the incredible team of dedicated professionals at RiverStone Health.

Chairman Cardin, Ranking Member Daines, and members of the committee, thank you for allowing me to share the current reality impacting our patients and oral health professionals. Your longstanding, bipartisan support changes our patients' and your constituents' lives every day. With sustained and expanded funding, health centers across the United States will continue to innovate and find new ways to provide improved access, equity, and quality of care to all those we serve.

On behalf of RiverStone Health and the Montana Primary Care Association, we appreciate this committee's commitment to addressing oral health disparities and welcome your questions once witness testimony has concluded.

SOURCE MATERIALS AND ADDITIONAL INFORMATION

Gill, S.A., Quinonez, R.B., Deutchman, M., Conklin, C.E., Rizzolo, D., Rabago, D., Haidet, P., and Silk, H. (2022), Integrating Oral Health into Health Professions School Curricula. *Medical Education,* 27(1), 2090308, *https://doi.org/10.1080/10872981.2022.2090308.*

NYU Langone Dental Residency Program, *https://www.nyulangonedental.org/about.*

Assessment of Mobile and Portable Dentistry Programs (2017), Oral Health Workforce Research Center, available at: *https://www.oralhealthworkforce.org/wp-content/uploads/2017/10/OHWRC_Mobile_and_Portable_Dentistry_Abstract_2017.pdf.*

Rodriguez, J.O. (March 17, 2023), Clinics on wheels bring doctors and dentists to health care deserts, NPR, retrieved March 26, 2023, from *https://www.npr.org/sections/health-shots/2023/03/17/1164118562/clinics-on-wheels-bring-doctors-and-dentists-to-health-care-deserts.*

Peters, S., Chandler, T., Hunt, D., and Famuliner, G. (n.d.), What Programs Exist and What Lessons Can We Learn From Their Successes and Challenges, School Based Health Alliance (SBHA) Toolkits, retrieved March 26, 2023, from *https://tools.sbh4all.org/school-oral-health-playbook/what-programs-exist-and-what-lessons-can-we-learn/.*

Mobile Dental Services Model—Rural Oral Health Toolkit (n.d.), Rural Health Information Hub (RHI) *https://www.ruralhealthinfo.org/toolkits/oral-health/2/mobile-dental-services-model.*

Niederman, R., Huang, S.S., Trescher, A.L., and Listl, S. (2017), Getting the Incentives Right: Improving Oral Health Equity With Universal School-Based Caries Prevention, *American Journal of Public Health,* 107(S1), S50–S55 *https://doi.org/10.2105/AJPH.2016.303614.*

QUESTIONS SUBMITTED FOR THE RECORD TO JONATHAN P. FORTE, MHA, FACHE

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. COVID–19 upended daily life and continues to impact our communities and our health-care system today. What are some lessons learned from the pandemic about oral health care and access to oral health care that the committee should be aware of?

Answer. On March 16, 2020, the American Dental Association (ADA) recommended suspension of elective dental procedures. As a result, 76 percent of dental offices in the U.S. closed, only seeing emergency patients, while 20 percent of dental offices in the U.S. closed completely. In Montana, most dental clinics shut down completely due to a lack of widespread testing, point of care availability, and high-risk nature of aerosolized dental procedures. Many individuals went without regular dental care, just as they did medical care, and providers are seeing more complex health issues across patient populations due to delays in care.

The CDC notes, "The COVID–19 pandemic has alarming implications for individual and collective health and emotional and social functioning" and that "healthcare providers have an important role in monitoring psychosocial needs and delivering psychosocial support to their patients." Research suggests a strong association between oral health conditions like erosion, caries, and periodontal disease and mood conditions like stress, anxiety, depression, and loneliness. Among those hospitalized with COVID–19, diabetes and cardiovascular disease are two of the most prevalent underlying comorbidities, according to the CDC. We know that periodontal disease is associated with diabetes and cardiovascular disease, so delays in dental care could have also exacerbated the mortality and morbidity rate of the COVID–19 pandemic.

What we now know is that when people have a way to pay for health needs (*i.e.,* insurance coverage) they will come and seek care. At RiverStone Health, our integrated care model and training programs allow family practice physicians and primary care providers to provide basic hygiene and screening services during medical visits. This level of preventative care must be replicated and available for reimbursement by payers.

As a result of COVID–19, patients are now receiving more invasive dental procedures due to delayed treatment and as such, experience a higher risk of psychological stress—related dental conditions. Continued support for statewide policies to expand access to oral health care and oral health promotion strategies for the vulnerable populations should be encouraged.

Question. As States resume redetermining who is eligible for Medicaid this Spring, we know that many people will lose their Medicaid coverage. Some will lose their coverage even if they are still eligible for it just for procedural reasons. How will these changes impact access to oral health care?

Answer. As of July 2023 in Montana, 75 percent of individuals (over 25,000) removed from Medicaid were due to administrative or procedural reasons. Only 25 percent or 8,433 individuals were appropriately deemed ineligible. Many Medicaid offices across the country have not been monitoring or updating patient addresses and contact information throughout the pandemic. Many Federally Qualified Health Center patients move frequently, causing changes to their addresses or phone numbers, while many more remain unhoused in our post pandemic housing crisis.

RiverStone Health took a proactive approach to contacting patients and correcting contact information, while also working one-on-one with Medicaid beneficiaries who present to appointments, verifying patient information in the Montana Medicaid portal. With over 6000 Medicaid enrollees, we have currently matched over 2,000 patients to ensure their benefits continue or connect them to resources for enrolling in other coverage.

Other than the obvious issue of removing health-care coverage from patients who rely on Medicaid for chronic medical conditions. Our primary oral health concern is removing individuals who are in the middle of active dental treatment plans, such as complex periodontal procedures, crowns, bridges, implants, or other medically necessary treatments which are proven to improve both quality of health and quality of life.

Once an individual is removed from Medicaid rolls, treatment is interrupted and might not continue. Patients who had Medicaid coverage may become eligible for sliding fee programs or forced to pay out of pocket for any remaining procedures.

States should suspend the redetermination of patients with currently active treatment plans until their oral health treatment plan is completed. RiverStone Health works with each patient on a case-by-case basis to ensure we can complete treatment plans and meet our patients' needs.

Question. Oral health is integral to overall health. Older adults and people with disabilities have some of the worst access to oral health coverage and oral health care, with particular inequities in access for people of color. For example, prior to the pandemic, 7 out of 10 Black Medicare beneficiaries and 6 out of 10 Hispanic beneficiaries reported they have not seen a dentist within the past year. Can you speak more about how older adults and people with disabilities are affected by a lack of affordable or accessible oral health coverage, particularly since oral health can impact other underlying conditions?

Answer. I spoke briefly about how oral health, behavioral health, cardiac health, and other conditions are all interconnected in a previous response. There are also downstream connections between COVID–19, Medicaid redetermination, and oral health. With the pandemic's impact on mental health, pandemic-related increases in oral health risk factors, and anticipated declines in per capita dental visits, increasing integrated practice and referrals between dental providers and behavioral health providers will be prudent. Oral care is health care. By increasing the availability of basic screening services in the primary care office, we can create more equitable access to oral health care. Similarly, increased efforts to more effectively integrate dental programs focused on prevention, screening, and risk assessment within primary care, obstetrics and gynecology, and pediatric offices should be pursued to expand access to oral health services for vulnerable populations.

With regards to older Americans, many of these patients simply do not get care. Many elderly patients also lack saliva which leads to additional oral health issues. Disparities in care across nursing homes further exacerbate oral health issues as many long-term care and independent living staff lack training to screen for or treat oral health concerns.

Medicare dental coverage outside of Medicare Advantage is necessary to improve access. According to the Kaiser Family Foundation (KFF), almost half of all Medicare beneficiaries did not have a dental visit within the past year (47 percent), with higher rates among those who are Black (68 percent) or Hispanic (61 percent), have low incomes (73 percent), or who are in fair or poor health (63 percent), as of 2018.

Eighty-eight percent of those who did seek care paid out of pocket. Average out-of-pocket spending on dental services among Medicare beneficiaries who had any dental service was $874 in 2018. One in five Medicare beneficiaries (20 percent) who used dental services spent more than $1,000 out of pocket on dental care.

In summary, since 1965, Medicare has not covered routine dental care and half of Medicare beneficiaries (47 percent) do not have any dental coverage, as of 2019. Our colleagues at KFF discovered that, without coverage, many people on Medicare forego needed and routine dental care—an issue that disproportionately impacts communities of color—with significantly fewer visits to the dentist in the past year among Black and Hispanic beneficiaries (68 percent and 61 percent, respectively) compared to White beneficiaries (42 percent). Untreated oral health can exacerbate certain chronic diseases, delay diagnosis of serious health conditions, and result in costly emergency visits.

Question. At the beginning of this year, Maryland's Medicaid program launched a comprehensive adult dental benefit. What, if any, lessons have been learned from States that have offered or are starting to offer comprehensive dental services to adults on Medicaid regarding the effect on health disparities for minority or other underserved populations at greatest risk of lack of access to oral health care?

Answer. Unfortunately, my experience with this expansion was limited due to my transition to Montana. I would encourage outreach to Dr. Sandra Garbely, DMD at Choptank Community Health System to garner additional specifics about access to care in Maryland and outcomes of this expansion of coverage.

One answer to our oral health access problem is that Medicare and Medicaid must provide expanded adult dental coverage. Medicaid adult dental coverage has been proven to reduce racial and ethnic disparities and improved outcomes for young adults, age 19–44.

Immediately following the launch of comprehensive dental services to adults in Maryland, we witnessed an increase in the number of appointments being requested, however access to care was hindered due to a lack of staffing, infrastruc-

ture, and availability of appointments coming out of the COVID–19 pandemic. While eligibility for care was increased, access to that care was difficult to come by due to a need for additional, qualified staff and the creation of professional career pipelines. Incentives for the recruitment and retention of dental providers are necessary to ensure continued access to care for all. Teaching Health Center appropriations and continued health center funding can go a long way to ensuring the sustainability of our workforce.

Research has shown, in expansion States providing dental benefits, compared with non-expansion States, access to dental coverage was associated with an 11-percent increase in the number of patients who reported seeing a dentist in the previous year and a 17-percent decrease in the prevalence of untreated decayed teeth. In States without Medicaid dental benefits, there was an increase in the average number of missing teeth and an almost 10-percent decrease in the prevalence of functional dentition (having 20 or more teeth).

PREPARED STATEMENT OF MARKO VUJICIC, PH.D., CHIEF ECONOMIST AND VICE PRESIDENT, HEALTH POLICY INSTITUTE, AMERICAN DENTAL ASSOCIATION

On behalf of the American Dental Association's Health Policy Institute, thank you, Chairman Cardin and Ranking Member Daines, for the opportunity to testify and share data-driven insights at today's hearing: "An Oral Health Crisis: Identifying and Addressing Health Disparities."

My name is Marko Vujicic. I am the chief economist and vice president of the Health Policy Institute at the American Dental Association. Over the past 12 years, I have led a team of researchers who study the U.S. dental care system, covering topics such as access to dental care, the dental workforce, dental care utilization, dental education, oral health outcomes, and more.

The American Dental Association is pleased to see that the Senate Finance Health Care Subcommittee has selected the topic of oral health as their first hearing of the 118th Congress. This is a testament of not only the important link between oral health and overall health and well-being, but a recognition that there is a need for action. We can and should do better when it comes to our Nation's oral health.

My testimony is focused around three main themes: the state of oral health in America; the policy choices we have made along the way; and considerations as we move forward.

THE STATE OF ORAL HEALTH IN AMERICA—KEY TRENDS TO HIGHLIGHT FROM THE DATA

Among U.S. children, oral health is improving. Over the past 2 decades, rates of untreated dental disease have been declining; dental care utilization has been increasing, particularly for key preventive services (*e.g.,* dental sealants); and more and more children are covered by some form of dental benefits.[1] These improvements have been most dramatic for low-income children and non-White children. In fact, in several States, including Texas, Hawaii, and Wyoming, dental care utilization rates for Medicaid-insured children are comparable to those of privately insured children.[2] New analysis shows that the mix of dental care services being provided to Medicaid-insured children is similar to those being provided to privately insured children.[3] When it comes to children's oral health in America, disparities by income and by race have been narrowing over time.

For working-age adults (age 19–64) and seniors (age 65 and older), the trends are different. For example, rates of untreated disease among working-age adults have not changed significantly over the past 2 decades, and disparities by income and race are persistent and much wider than for children. The percent of working-age adults who visit a dentist in the course of a year is actually slightly lower today than 2 decades ago. For seniors, dental care utilization rates have increased over

---

[1] National Institute of Dental and Craniofacial Research, Oral Health in America: Advances and Challenges, 2021, Bethesda, MD: National Institutes of Health, available from: *https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf,* accessed March 24, 2023.

[2] American Dental Association, Dental care use among children: 2016, Health Policy Institute, infographic, July 2018, available upon request.

[3] Nasseh K., Fosse C., Vujicic M., Comparative analysis of dental procedure mix in public and private dental benefits programs, *JADA,* 2022;153(1):P59–66.

time, but the disparities by income and by race have been stable. In fact, gains in some oral health measures, such as reductions in tooth loss, are concentrated among high-income seniors.[4] Overall, disparities in oral health are stable for working-age adults and seniors.[5]

In any given year, less than half of the U.S. population visits a dentist.[6] But oral health in America is a two-part story. We have seen 2 decades of steady improvements among children, particularly the most vulnerable, in tandem with much less progress among working-age adults and seniors.

THE POLICY CHOICES WE HAVE MADE ALONG THE WAY

The trends in oral health we observe are a result of how dental care is handled in Federal and State health policy, particularly the different policy approach for children compared to working-age adults and seniors. Comprehensive dental coverage is a requirement in Medicaid and CHIP programs and is part of the essential health benefit under the Affordable Care Act. As a result, over 90 percent of U.S. children are covered by dental insurance and this percentage has been increasing steadily the past 2 decades. Because dental care is an essential service, there are checks and balances in place to ensure a comprehensive basket of dental care services is covered for children with minimal cost sharing among beneficiaries.

For working-age adults and seniors, the policy approach has been very different. Dental care is not considered an essential health benefit. Medicaid programs are not required to cover dental care services for adults, and traditional Medicare does not cover dental services except in certain circumstances that are linked to medical procedures. The Affordable Care Act did not include adult dental care as an essential health benefit.

As a result, there is considerable variation, for example, in adult dental coverage within State Medicaid programs. As of October 2022, only half of States provide comprehensive dental coverage to adults in their Medicaid programs.[7] However, more and more States have added dental coverage for adults over the past several years, including all State Medicaid programs now providing dental coverage during pregnancy and for at least 60 days post-partum.[8]

For seniors, dental coverage is an optional benefit within Medicare Advantage, with 94 percent of enrollees having some form of dental coverage as part of their plan. However, the range of dental care services covered within these plans varies considerably, with some covering only preventive services. Most plans have considerable coinsurance rates (*e.g.,* 50 percent) for dental care services beyond routine check-ups and cleanings.[9] There is very little data available on utilization rates for supplemental benefits, including dental care, among Medicare Advantage enrollees.[10] However, a recent study found that dental care utilization rates and certain measures of oral health decline when people reach Medicare eligibility and, more significantly, there were no differences between enrollees in traditional Medicare

---

[4] Dye B.A., Weatherspoon D.J., Lopez Mitnik G., Tooth loss among older adults by poverty status in the United States from 1999–2004 to 2009–2014, *JADA,* 2019;150(1):9–23.e3.

[5] Yarbrough C., Vujicic M., Oral health trends for older Americans, *JADA,* 2019;150(8):714–716.

[6] Manski R., Rohde F., Ricks T., Trends in the Number and Percentage of the Population with Any Dental or Medical Visits, 2003–2018, Agency for Healthcare Research and Quality, statistic brief #537, October 2021, available from: *https://meps.ahrq.gov/data_files/publications/st537/stat537.pdf,* accessed March 24, 2023.

[7] National Academy for State Health Policy, State Medicaid Coverage of Dental Services for General Adult and Pregnant Populations, updated October 20, 2022, available from: *https://nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/,* accessed March 24, 2023.

[8] U.S. Department of Health and Human Services, HHS Approves 12-month Extension of Postpartum Medicaid and CHIP Coverage in North Carolina, September 22, 2022, available from: *https://www.hhs.gov/about/news/2022/09/22/hhs-approves-12-month-extension-of-postpartum-medicaid-and-chip-coverage-in-north-carolina.html,* accessed March 24, 2023.

[9] Freed M., Ochieng N., Sroczynski N., Damico A., Amin K., Medicare and Dental Coverage: A Closer Look, Kaiser Family Foundation, issue brief, July 28, 2021, available from: *https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/,* accessed March 24, 2023.

[10] Government Accountability Office, Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization, report to congressional committees, GAO–23–105527, January 2023, available from: *https://www.gao.gov/assets/gao-23-105527.pdf,* accessed March 26, 2023.

compared to Medicare Advantage.[11] Of all the supplemental benefits, Medicare Advantage enrollees report the most confusion and dissatisfaction about dental coverage.[10]

Due to the very different policy approaches taken toward dental care for children compared to working-age adults and seniors, we see vastly different degrees of financial barriers to dental care. A much larger share of working-age adults and seniors report they cannot access needed dental care services due to affordability issues compared to children.[12] Moreover, "cost" is the top reason working-age adults and seniors are not able to access dental care, and financial barriers are more severe for dental care than any other health-care service (*e.g.,* prescription drugs, mental health, physician services). This is a direct consequence of policy choices.

Essentially, our health policy approach disconnects the mouth from the body when you become an adult.

KEY CONSIDERATIONS FOR POLICY MAKERS MOVING FORWARD

As policymakers consider ways to address the oral health issues facing the Nation, there are some important findings from the data and evidence that I wish to highlight.

The Economic and Fiscal Dividend of Improved Oral Health

Beyond the fact that you cannot be healthy without a healthy mouth,[13] there is compelling empirical evidence of the economic benefits associated with improved oral health. Oral health issues limit job prospects, hinder workplace productivity, and limit employee earnings. An estimated 29 percent of low-income adults in the U.S. report that the appearance of their mouth and teeth affects their ability to interview for a job.[14] For low-income adults living in States that do not provide adult dental coverage in their Medicaid program, this figure jumps to 60 percent. When States provide comprehensive adult dental coverage in their Medicaid program, the job prospects of Medicaid beneficiaries improve and the effect is most significant for Black Medicaid beneficiaries.[15] Investing in oral health improves job prospects and helps narrow economic disparities.

There is new research linking improved oral health with reduced overall health-care spending. These links are strongest for certain medical conditions like diabetes, heart disease, and pregnancy. One study shows that newly diagnosed diabetics see reductions in health-care spending if they receive certain dental care treatments while those that go without dental care do not.[16] Among pregnant women, when dental care is included as part of routine prenatal care, overall medical care costs associated with the pregnancy are lower.[17]

Every 15 seconds in America, someone shows up at a hospital emergency department because of a dental issue. The estimated 2.1 million emergency department visits for dental conditions cost the U.S. health-care system $2.7 billion each year,

---

[11] Simon L., Song Z., Barnett M.L., Dental services use: Medicare beneficiaries experience immediate and long-term reductions after enrollment, *Health Affairs,* 2023; 42(2):286–295.

[12] Vujicic M., Fosse C., Time for dental care to be considered essential in U.S. health-care policy, *JAMA Ethics,* 2022; 24(1):E57–63.

[13] U.S. Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General, Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, available from: *https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf,* accessed March 24, 2023.

[14] American Dental Association, Oral Health and Well-Being in the United States, Health Policy Institute, infographic, 2015, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf,* accessed March 26, 2023.

[15] Vujicic M., Fosse C., Reusch C., Burroughs M., Making the Case for Dental Coverage for Adults in All State Medicaid Programs, American Dental Association, Health Policy Institute White Paper, July 2021, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf,* accessed March 24, 2023.

[16] Nasseh K., Vujicic M., Glick M., The relationship between periodontal interventions and healthcare costs and utilization, evidence from an integrated dental, medical, and pharmacy commercial claims database, *Health Economics,* 2017;26:516–527.

[17] Jeffcoat M.K., Jeffcoat R.L., Gladowski P.A., Bramson J.B., Blum J.J., Impact of periodontal therapy on general health: Evidence from insurance data for five systemic conditions, *Am J Prev Med.* 2014;47(2): 166–174.

with Medicaid accounting for the largest share of this spending.[18] This is an example of inefficient spending that could be avoided if more Americans had access to a dental home for routine care and prevention.

The American Dental Association's Health Policy Institute has developed a quantitative model to estimate the fiscal impact of alternative adult dental coverage policies in Medicaid on State budgets. In addition to estimating additional dental care spending, the model incorporates the fiscal offsets associated with reduced emergency room costs as well as reduced medical care costs. The net cost of adding comprehensive adult dental benefits into all State Medicaid programs that currently do not provide such benefits is estimated at $836 million per year.[19] Detailed analysis has been provided to State legislatures in Maine, Hawaii, Virginia, and Florida.[20, 21, 22, 23]

Investing in oral health also impacts the local economy beyond reduced healthcare costs, improved job prospects, and overall wellbeing. Each dental practice is estimated to contribute $2.3 million annually to the local economy when the various direct and indirect effects are taken into consideration.[24] Overall productivity losses associated with untreated oral disease were estimated to be $45.9 billion per year in the U.S., much higher than any other country.[25]

As a Nation, we are paying an economic penalty for how we address dental care within health policy.

A Dental Workforce That Is Sufficient, Diverse, Healthy, and Located Where it is Needed Most

As in much of health care, the COVID–19 pandemic significantly disrupted the labor market for dental team members. Dental practices are having a tough time finding qualified staff, particularly dental hygienists and dental assistants. As of March 2023, 96 percent of dentists report it is extremely or very difficult to fill vacant dental hygienist positions and 86 percent of dentists report the same for dental assistant positions.[26] Enrollment in dental hygiene programs has only recently recovered to pre-pandemic levels while enrollment in dental assisting programs has been on a steady decline since before the pandemic.[27] As a result, the current staffing shortage for dental hygienists and dental assistants is likely to persist for several years. In the interim, there are strategies for employers to effectively recruit

---

[18] American Dental Association, Emergency Department Visits for Dental Conditions—A Snapshot, Health Policy Institute, infographic, April 2020, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0420_1.pdf,* accessed March 24, 2023.

[19] Vujicic M., Fosse C., Reusch C., Burroughs M., Making the Case for Dental Coverage for Adults in All State Medicaid Programs, American Dental Association, Health Policy Institute White Paper, July 2021, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf,* accessed March 24, 2023.

[20] Vujicic M., Fosse C., Estimating the Cost of Introducing Comprehensive Medicaid Adult Dental Benefits in Florida, American Dental Association, Health Policy Institute, research brief, May 2021, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0621_1.pdf,* accessed March 24, 2023.

[21] Vujicic M., Fosse C., Estimating the Cost of Introducing a Medicaid Adult Dental Benefit in Maine, American Dental Association, Health Policy Institute, research brief, March 2021, available from: *https://www.mainecohn.org/assets/docs/ADA_HPI_Estimating_the_Cost_of_MADB_in_Maine_FINAL.pdf,* accessed March 24, 2023.

[22] Vujicic M., Starr R.R., Fujii D.F., Starkel Weninger R., Harrison B., Estimating the Cost of Introducing Comprehensive Medicaid Adult Dental Benefits in Hawaii, Association, Health Policy Institute, research brief, February 2020, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0220_1.pdf,* accessed March 24, 2023.

[23] Vujicic M., Starkel R., Harrison B., Estimating the Cost of Introducing Comprehensive Medicaid Adult Dental Benefits in Virginia, Association, Health Policy Institute, research brief, January 2020, available from: *https://vahealthcatalyst.org/wp-content/uploads/2020/02/HPI-Report-with-Intro-Letter_Update.pdf,* accessed March 24, 2023.

[24] American Dental Association, Total economic impact of dentists: Over $350 billion, December 2022, available upon request.

[25] Righolt A.J., Jevdjevic M., Marcenes W., Listl S., Global-, regional-, and country-level economic impacts of dental diseases in 2015, *J Dent Res.* 2018:22034517750572.

[26] American Dental Association, Economic outlook and emerging issues in dentistry. Insights from data from March 2023, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/mar2023COVID-19hpi_economic_outlook_dentistry_slides_2023.pdf,* accessed March 24, 2023.

[27] American Dental Association, Survey of Allied Dental Education Programs, 2021–22, report 1, table 1, Health Policy Institute, Commission on Dental Accreditation, available from: *https://www.ada.org/resources/research/health-policy-institute/dental-education,* accessed March 26, 2023.

and retain staff[28] and for State and Federal policymakers to boost training capacity.[29]

Like many other health-care professions, the pandemic took a toll on the mental health and well-being of dental team members. Levels of anxiety and depression spiked mid-2020 and then steadily decreased through 2021.[30]

Beyond the disruptions associated with the COVID–19 pandemic, the supply of dentists per capita is predicted to be steady through 2025 and then to increase significantly after that.[31] However, between 2011 and 2021, the number of dentists per 100,000 population increased from 60.8 to 62.8 in urban areas while decreasing from 37.3 to 36.5 in rural areas. This is an important issue to highlight, as geographic access to dental care providers in rural areas is much lower than in urban areas.[32] There are several policy options to consider to attract and retain more dental care providers in rural areas, including loan forgiveness programs tied to geographic areas, education pathway programs, enhanced mobile clinics, alternative workforce models and scope of practice, and targeted visa programs, to name a few.[33]

Related to geographic access to dentists, it is important to note that conventional methods of designating "shortage areas" for dental care providers—including the methodology used by HRSA—are significantly flawed. Much has been written about the drawbacks, including a concise two-page summary,[34] and the American Dental Association's Health Policy Institute has developed an alternative, peer-reviewed methodology that addresses these shortcomings. The American Dental Association's Health Policy Institute has offered, and continue to offer, to assist government agencies in any way to improve the data and methods for assessing provider adequacy. In the meantime, the analysis for every State, including a separate analysis for Medicaid beneficiaries, can be accessed on the American Dental Association's Health Policy Institute website.[35]

Among Medicaid beneficiaries, particularly adults, finding a dentist who participates in the Medicaid program is an important barrier to care in many States. One out of three dentists in the U.S. sees at least one Medicaid patient in the course of a year. A mere 18 percent of dentists see at least 100 Medicaid patients per year. There is significant variation in these kinds of statistics by State and dentist characteristics. At the State level, Vermont, Missouri, and Montana have the highest shares of dentists seeing a high volume of Medicaid patients.[36]

Policymakers have a considerable body of evidence at their disposal to design effective policies that can boost provider participation in Medicaid. These "good practices" are well documented and include streamlined credentialing and broader administrative practices, sufficient fees, patient navigation assistance to reduce missed

---

[28] ADA Health Policy Institute in collaboration with American Dental Assistants Association, American Dental Hygienists' Association, Dental Assisting National Board, and IgniteDA. Dental Workforce Shortages: Data to Navigate Today's Labor Market, October 2022, available from: *https://www.ada.org/resources/research/health-policy-institute/dental-practice-research/dental-workforce-shortages,* accessed March 24, 2023.

[29] Garvin J., Oregon Dental Association supports bill to increase recruitment, retention of dental support staff, *ADA News,* March 2, 2023, available from: *https://www.ada.org/publications/ada-news/2023/march/oregon-dental-association-supports-bill-to-increase-recruitment-of-dental-support-staff,* accessed March 24, 2023.

[30] Eldridge L.A., Estrich C.G., Gurenlian J.R., et al. US dental health-care workers' mental health during the COVID–19 pandemic, *JADA,* 2022;153(8):P740–749.

[31] Munson B., Vujicic M., Projected Supply of Dentists in the United States, 2020–2040, American Dental Association, Health Policy Institute, research brief, May 2021, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0521_1.pdf,* accessed March 24, 2023.

[32] Nasseh K., Eisenberg Y., Vujicic M., Geographic access to dental care varies in Missouri and Wisconsin. *Public Health Dent.* 2017;77(3):197–206.

[33] Oral Health Workforce Research Center, How Evidence-based Is US Dental Workforce Policy for Rural Communities? Center for Health Workforce Studies, School of Public Health, University at Albany, September 2020, available from: *https://oralhealthworkforce.org/wp-content/uploads/2020/10/OHWRC_Dental_Workforce_Policy_for_Rural_Communities_2020.pdf,* accessed March 24, 2023.

[34] Vujicic M., A new way to measure geographic access to dentists in North Carolina, *North Carolina Medical Journal,* 2017. 78(6):391–392.

[35] American Dental Association, Geographic Access to Dental Care, Health Policy Institute, available from: *https://www.ada.org/resources/research/health-policy-institute/coverage-access-outcomes/geographic-access-to-dental-care,* accessed March 24, 2023.

[36] Vujicic M., Nasseh K., Fosse C., Dentist participation in Medicaid: How should it be measured? Does it matter? American Dental Association, Health Policy Institute Research Brief, October 2021, available from: *https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1021_1.pdf,* accessed March 24, 2023.

appointments, and expanded scope of practice for dental team members. What has been studied less is the role of individual dentist characteristics and practice modalities in the Medicaid participation decision. New research[37] indicates that, all else equal, racially and ethnically diverse dentists are far more likely to see a high volume of Medicaid patients. Dentists in large group practices are also more likely than solo practitioners to see a high volume of Medicaid patients. As dental school enrolment diversifies[38] and more dentists practice in larger groups,[39] this could lead to more dentists, in aggregate, participating in Medicaid.

The dentist workforce does not reflect the U.S. population when it comes to racial and ethnic diversity. The latest data indicate that Black and Hispanic dentists are significantly underrepresented in relation to the U.S. population overall.[40] For example, 3.8 percent of dentists are Black compared to 12.4 percent of the U.S. population. Similarly, 5.9 percent of dentists are Hispanic compared to 18.4 percent of the U.S. population. Dental school enrollment data indicate a slight increase in diversity. For the 2021–22 school year, 7.3 percent of first-year dental students were Black and 10.7 percent were Hispanic, meaning we can expect a more diverse workforce in the future.

The Importance of Addressing Cost Barriers to Dental Care

The evidence is compelling that the most important barriers to dental care for working-age adults and seniors relate to affordability, particularly for those of low income. Lack of dental coverage as well as shortcomings in the status quo model of dental insurance for working-age adults and seniors are key factors driving up financial barriers to dental care. There are a host of policy approaches that could be explored to address affordability. These include improving transparency and accountability within the private dental insurance market through, for example, applying minimal loss ratios to dental insurance plans, setting out-of-pocket payment limits for patients or, even more simply, requiring better data reporting.[41] The private dental insurance model as it currently operates is not true insurance, as it almost universally has an annual maximum benefit and significant coinsurance rates for services beyond prevention. Policymakers could explore broader reforms such as classifying dental care as an essential benefit for all age groups, using the key policy parameters around children's dental care as a framework.

Chairman Cardin and Ranking Member Daines, thank you again for this opportunity to share with you and the subcommittee some key data-driven insights on our Nation's oral health. The American Dental Association looks forward to working with the Senate Finance Committee to continue to tackle this important area of health policy.

QUESTIONS SUBMITTED FOR THE RECORD TO MARKO VUJICIC, PH.D.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. COVID–19 upended daily life and continues to impact our communities and our health-care system today. What are some lessons learned from the pandemic about oral health care and access to oral health care that the committee should be aware of?

Answer. The pandemic highlighted that dental care is an essential service. Through the pandemic, and through the early stages of recovery, dentists were seeing the consequences of delayed or missed dental care appointments, with increased treatment needs. As with the rest of the health-care system, the most vulnerable

---

[37] Nasseh K., Fosse C., Vujicic M., Dentists who participate in Medicaid: Who they are, where they locate, how they practice, *Med Care Res and Rev,* 2022;80(2):245–252.

[38] American Dental Association, Dental education program enrollment and graduates report: 2021–22, Health Policy Institute, updated June 2022, available from: *https://www.ada.org/resources/research/health-policy-institute/dental-education,* accessed March 24, 2023.

[39] American Dental Association, How Big Are Dental Service Organizations? Health Policy Institute, infographic, July 2020, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0720_1.pdf,* accessed March 24, 2023.

[40] American Dental Association, Racial and Ethnic Mix of the Dentist Workforce in the U.S., Health Policy Institute, April 2021, available from: *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0421_1.pdf,* accessed March 24, 2023.

[41] Vujicic M., Gupta N., Nasseh K., Why we need more data on the dental insurance market, *JADA,* 2018;149(1):75–77.

groups were hardest hit, seeing the biggest increase in unmet needs. Fast forwarding to today, the latest data show that among the Medicaid-insured population, dental care utilization still remains well below pre-pandemic levels. Part of this is likely due to capacity constraints driven by staffing shortages. But part of also likely reflects how the pandemic has had a long term impact on health equity.

Question. As States resume redetermining who is eligible for Medicaid this Spring, we know that many people will lose their Medicaid coverage. Some will lose their coverage even if they are still eligible for it just for procedural reasons.

How will these changes impact access to oral health care?

Answer. Unequivocally, this will have a negative effect on access to oral health. For U.S. children, Medicaid coverage for dental care is an essential driver of the progress we have seen in oral health. Comprehensive dental coverage for children in Medicaid and CHIP programs has helped expand access to dental care for millions of children, and this had led to narrowing disparities in oral disease by income and race. For adults, the past few years have seen many state Medicaid programs expand (optional) dental coverage, recognizing the importance of oral health for low-income adults. These gains are threatened in states that reform their eligibility policies to reduce enrolment.

Question. Oral health is integral to overall health. Older adults and people with disabilities have some of the worst access to oral health coverage and oral health care, with particular inequities in access for people of color. For example, prior to the pandemic, 7 out of 10 Black Medicare beneficiaries and 6 out of 10 Hispanic beneficiaries reported they haven't seen a dentist within the past year.

Can you speak more about how older adults and people with disabilities are affected by a lack of affordable or accessible oral health coverage, particularly since oral health can impact other underlying conditions?

Answer. This is not a topic the ADA Health Policy Institute has studied. Yet.

Question. At the beginning of this year, Maryland's Medicaid program launched a comprehensive adult dental benefit.

What, if any, lessons have been learned from states that have offered or are starting to offer comprehensive dental services to adults on Medicaid regarding the effect on health disparities for minority or other underserved populations at greatest risk of lack of access to oral health care?

Answer. Maryland has been a leader in highlighting the essentialism of oral health and in adopting policies to expand access to dental care for vulnerable populations. Adding comprehensive adult dental benefits to the Medicaid program is the latest step. There is strong evidence linking Medicaid policy on dental coverage for adults and cost barriers to dental care, dental care utilization, oral health status, and employability. Studies show that when adults gain dental coverage through Medicaid, they report improved oral health and employability. These outcomes are most pronounced among Black Medicaid enrollees and those who had gone without dental coverage for more than a year, suggesting that dental coverage has the potential to reduce inequities in the oral health care delivery system. Providing dental coverage to adults in Medicaid programs increases access to and utilization of dental care. There are economic benefits to adult dental coverage in Medicaid as well. Among Medicaid-enrolled adults in States with no dental coverage for adults in their Medicaid program, 60 percent report that the appearance of their mouth and teeth affects their ability to interview for a job. For those in states with comprehensive Medicaid dental coverage for adults, it was much lower, at 35 percent. The Medicaid Dental Benefit Act of 2023 (S. 570) would make comprehensive dental care a mandatory component of Medicaid coverage for adults in every state. This bill, supported by the American Dental Association, would help reduce disparities in oral health among adults in the U.S.

Question. The Centers for Medicare and Medicaid Services (CMS) have a framework for health equity that includes a priority related to expanding the collection, reporting, and analysis of data, including demographic data, to better understand disparities.

What, if any, challenges have you observed in using data to understand the state of oral health and oral health disparities in the United States?

What actions would you like to see the Federal Government take to address these challenges?

Answer. There are three broad areas for consideration I feel are important for improving the data infrastructure for better insights on health equity. First, it is important to expand/replace the type of data collected from large population-based surveys (*i.e.,* NHIS, MEPS) to include patient-reported outcomes related to oral health (*e.g.,* OHIP–5 measures). Second, it is important for federal agencies to adopt a consistent methodology for collecting race and ethnicity data across numerous surveys. Third, the methodology for identifying health professional shortage areas needs to be modernized and updated. I am happy to follow up and expand on these points as needed.

COMMUNICATIONS

AARP

April 12, 2023

The Honorable Benjamin Cardin
Chairman
U.S. Senate
Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

The Honorable Steve Daines
Ranking Member
United States Senate
Committee on Finance
Subcommittee on Health Care
Washington, DC 20510

Dear Chairman Cardin and Ranking Member Daines:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to submit a written statement for the record to the Subcommittee on Health Care of the Committee on Finance for the March 29, 2023, hearing entitled "An Oral Health Crisis: Identifying and Addressing Health Disparities". Lack of access to affordable dental care can have profound health consequences across populations. Older Americans, in particular, know that oral health affects all aspects of their health and well-being. Poor oral hygiene can cause complications for people with chronic conditions, hasten cognitive decline, lead to social isolation, and increase overall health care expenses.

Medicare is crucial to Americans' ability to lead full and active lives as we age. However, traditional Medicare, which serves about half the people enrolled in the program, does not cover routine dental care.[1] By law, Medicare does not pay for preventive or diagnostic services such as teeth cleanings or x-rays. It also does not cover basic restorative procedures like fillings, nor more complex restorative care like dentures or implants.

Unfortunately, nearly half of Medicare beneficiaries do not have any dental coverage[2] and are therefore responsible for the entire cost of all routine dental services. Without oral health coverage, many people with traditional Medicare pay out-of-pocket or simply forego dental visits. Those who want coverage must buy separate dental insurance or enroll in Medicare Advantage, which typically offers very limited dental coverage, if any. Some people with limited resources can get dental coverage through Medicaid. In any scenario, the level of coverage, access, and affordability for older Americans varies considerably.

The impact is clear: many people with Medicare face significant barriers to accessing the dental care they need. About 17 million individuals with traditional Medicare (or roughly 44% of the traditional Medicare population) did not see a dentist in the past year.[3] Going without dental care is an issue that disproportionately impacts certain demographic groups within traditional Medicare—including people

---

[1] *https://www.cms.gov/Medicare/Coverage/MedicareDentalCoverage.*

[2] *https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/.*

[3] Estimates for the number of people who did not see a dentist and for out-of-pocket spending on dental care are based on AARP Public Policy Institute's analysis of the 2019 Medicare Current Beneficiary Survey (MCBS). Data on dental service utilization across Medicare Advantage plans is not available.

from Black/African American and Hispanic/Latino communities, beneficiaries with low incomes,[4] and people who live in rural areas.[5]

Recently, the Centers for Medicare and Medicaid Services revised their policy to allow Medicare coverage for "medically necessary" dental care that is integral and inextricably linked to the success of a covered health service. This policy change will allow Medicare beneficiaries to receive the prerequisite oral care needed for organ transplants, cancer treatment, or many other health services. Before this change, the lack of coverage for oral care created a barrier, preventing access to the life-saving treatments that are covered. We applaud CMS for this significant step of covering "medically necessary" oral health care, but more should be done.

We urge the Committee to consider greater coverage of dental services—including routine care—under traditional Medicare, which would benefit millions of people and address both oral and medical health needs. Including comprehensive dental coverage in traditional Medicare as a Part B benefit is a responsible way to ensure all older Americans have access to the care they need. Increased Medicare dental coverage would be a very good investment in peoples' health and well-being, and a good investment in the Medicare program. Proper dental care can prevent infection, reduce hospitalizations, and help manage expensive chronic conditions such as diabetes and heart disease. Furthermore, a healthy mouth and teeth are necessary for good nutrition and communication, which help prevent dementia and social isolation and their associated costs.

It is long past time for Medicare to cover the full person—from head to toe. AARP thanks the Committee for examining oral health coverage and looks forward to working with you to ensure more Americans have access to the care they need. If you have any questions, feel free to contact me or have your staff contact Andrew Scholnick on our Government Affairs team at ascholnick@aarp.org.

Sincerely,

Bill Sweeney
Senior Vice President
Government Affairs

ACADEMY OF GENERAL DENTISTRY
560 W. Lake St., 6th Floor
Chicago, IL 60661–6600
312–440–4300
Fax: 312–440–0559
Toll-free: 888–243–3368
https://www.agd.org/

The Academy of General Dentistry, on behalf of our membership and our patients, submits this statement for the record concerning the hearing entitled, "An Oral Health Crisis: Identifying and Addressing Health Disparities," before the Senate Committee on Finance Subcommittee on Health on March 29, 2023.

As the only dental association solely dedicated to the interests of general dentists, the largest segment of the dental profession, and as the second largest professional dental organization, the AGD recognizes the important role it can play in advancing oral health care for every individual. Founded in 1952, the AGD's mission is to "advance general dentistry and oral health through quality continuing education and advocacy" through its nearly 40,000 members.

INTRODUCTION AND LANDSCAPE

Oral Health Is Critical to Overall Well-being

Studies have long documented the importance of an individual's oral health to their overall well-being. One journal from 2017 stated "the oral cavity is the intersection of medicine and dentistry and the window into the general health of a patient."[1] This holds true for patients across their lifespan, from birth, to adolescence, to early adulthood, to women who are pregnant or postpartum, and to those at the end of

---

[4] *https://www.healthyagingpoll.org/reports-more/report/dental-care-coverage-after-65-experiences-perspectives.*

[5] *https://www.aarp.org/content/dam/aarp/research/surveys_statistics/health/2021/health-care-rural-america-dental-health.doi.10.26419-2Fres.00447.002.pdf.*

[1] Patricia Alpert, Oral Health: The Oral-Systemic Health Connection, *SAGE Journals, https://journals.sagepub.com/doi/abs/10.1177/1084822316651658* (accessed March 20, 2023).

life. Research estimates that over 100 systemic diseases have oral manifestations.[2] For example, the Mayo Clinic states that poor oral health may contribute to various diseases and conditions, including: (1) endocarditis when bacteria from the mouth spreads through the bloodstream, (2) cardiovascular disease which may be linked to infections caused by oral bacteria, (3) birth complications, and (4) pneumonia. Additionally, poor oral health can also be an indicator of diseases such as diabetes, HIV/AIDS, osteoporosis, and Alzheimer's disease. Research also notes other conditions that might be linked to poor oral health, including eating disorders and poor nutritional intake, rheumatoid arthritis, certain cancers and immune system disorders.[3] Additionally, dentists often catch many illnesses and conditions before they are diagnosed by a physician, because patients may visit their dentists more regularly for routine care. Further, because many medical issues are asymptomatic patients may therefore not see a need to visit their physicians as frequently. Dentists often refer patients to physicians who are hypertensive, have suspicious lesions in their mouth or on their face, or have uncontrollable gingivitis (which may be an indicator of diabetes or early signs of leukemia). All of these conditions, either ones that are caused by or may result in poor oral health, affect significant portions of the population. Optimization of a patient's health through both primary and dental health care can alleviate many of these disease burdens on individuals and on the health care system as a whole.

Although dentistry accounts for just 4 percent of total national health expenditures,[4] dental health care can help prevent the worsening of certain illnesses and ultimately reduce costs to both the individual patient and the overall health care system. For example, one study estimates that illnesses related to oral health result in 6.1 million days of bed disability, 12.7 million days of restricted activity, and 20.5 million days of lost workdays each year.[5] Additionally, data indicates that costs associated with nontraumatic emergency room visits for dental procedures may exceed $1.7 billion per year.[6] Therefore, it is important to note that, unlike medical treatments, the vast majority of oral health conditions are preventable through oral health literacy, sound hygiene, and preventive care.

Providing patients with routine dental health care will help them avoid worsening health conditions and prevent them, and the health care system, from incurring unnecessary costs. For example, general dentists can help identify early signs of tooth decay, which can help patients avoid developing cavities or infections. If patients develop oral infections, particularly those with preexisting conditions such as diabetes or certain cardiovascular conditions, they can experience severe health complications that result in being admitted to an emergency room.

Additionally, the AGD focuses on prevention, screening, early detection, and treatment of oral/oropharyngeal cancer. The philanthropic arm of the AGD offers grants to programs that perform oral cancer screenings and educates general dentists on improving screening techniques and sending patients for referrals and care if necessary. By improving and expanding oral cancer screenings, dentists can help diagnose patients at an early stage, when outcomes are much more favorable.

Regulatory Environment for General Dentists

Dentists are heavily impacted by the changing regulatory environment and increased administrative burdens. In addition, debates around expanding access to dental care too often fail to take into consideration significant differences between the oral health payment and delivery system and the medical system. The Academy of General Dentistry (AGD) advocates for the interests of general dentists, both as

---

[2] Shawn F. Kane, The Effects of Oral Health on Systemic Health, General Dentistry Research Brief, *https://www.agd.org/docs/default-source/self-instruction-(gendent)/gendent_nd17_aafp_kane.pdf* (accessed March 20, 2023).

[3] Mayo Clinic Staff, Oral Health: A Window to Your Overall Health, Mayo Clinic, *https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475* (accessed March 20, 2023).

[4] CMS, National Health Expenditures 2017 Highlights, *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf* (accessed March 20, 2023).

[5] U.S. Department of Health and Human Services, Oral Health in America: A Report of the Surgeon General, Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000, NIH publication 00–4713. Available from: URL: *http://www.surgeongeneral.gov/library/oralhealth/*.

[6] Wall, T., Nasseh, K., Vujicic, M., Majority of Dental-Related Emergency Department Visits Lack Urgency and Can Be Diverted to Dental Offices, ADA Research Brief, August 2014, *https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx* (accessed March 20, 2023).

an organization and in partnership with other dental associations. As clinicians, we advocate for the best interests of our patients and oppose third party interference with the doctor-patient relationship. Specifically, the AGD believes that health care reform should:

1. Be market-based and foster competition;
2. Be based on a dental prevention/dental home model for oral health care;
3. Reduce administrative burdens;
4. Address state level reforms; and
5. Encourage healthy lifestyles, good oral health habits, and personal responsibility.

Priority Issues of Concern

The AGD would like to bring focus on four priorities we urge this Committee, and Congress, to act on: (1) improving access to dental health care for all Americans; (2) providing a supportive regulatory and tax environment necessary for a robust dental care industry; (3) ensuring supportive Medicaid policies and coverage of dental services; and (4) addressing Medicare policies and noncoverage of dental services.

I. Ensuring Access to Dental Health Care

The AGD cares deeply about ensuring that every American has access to oral health care. As discussed previously, oral health care is a critical predictor and indicator of overall well-being. Unfortunately, not everyone has access to dental health care, and these rates are significantly worse for underserved populations. For example, people who are located in rural areas, have lower incomes, and are Hispanic and non-Hispanic Black, are less likely to have had a dental visit within the last year, according to 2019 data from the Centers for Disease Control and Prevention (CDC).[7] Additionally, those without insurance are less likely to seek or receive dental health care.[8] Even for those with insurance, a 2021 survey found that nearly half of all Americans with insurance skipped a dental visit because of cost.[9]

High costs and other barriers to care, such as a lack of transportation, are the most commonly cited reasons why patients forgo dental health care.

Dentists desire to serve each and every individual with the best possible care, but simply are unable to because of a lack of adequate policy. For example, dentists support programs such as dental loan repayment programs, which place new graduates in underserved areas. Dental organizations host large annual campaigns to fund care for children from underserved communities. Further, although dentistry is seen as a predominantly hands-on profession, dentists utilized telehealth to provide care for patients during the pandemic. Therefore, we urge the Committee and Congress to consider policies that will help expand and protect access to dental health care for all.

II. Tax Policies

Dentistry is unique in health care in that it is essentially a small business. The model of a dentist's office is quite different than a model of a physician's office, a hospital-physician group, etc. Thus, it is particularly important to prioritize policies that help protect and empower small businesses to ensure dental practices can provide sustained and high-quality care for their patients.

First, many studies document disparities in access to oral health care by geography—individuals living in rural or less economically advantages areas are less likely to have access to dental care.[10, 11, 12] Unfortunately, high educational debt and

---

[7] Cha, A.E., Cohen, R.A., Urban-rural Differences in Dental Care Use Among Adults Aged 18–64, NCHS Data Brief, no 412, Hyattsville, MD: National Center for Health Statistics, 2021, DOI: *https://pubmed.ncbi.nlm.nih.gov/34310273/* (accessed March 20, 2023).

[8] Chad D. Meyerhoefer, Irina Panovska, and Richard J. Manski, Projections of Dental Care Use Through 2026: Preventive Care to Increase While Treatment Will Decline, *Health Affairs, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0833* (accessed March 20, 2023).

[9] Michelle Lambright Black, Nearly Half of Insured Americans Skip Dental Visits, Procedures Due to Cost, Value Penguin, *https://www.valuepenguin.com/dental-survey* (accessed March 20, 2023).

[10] Mary E. Northridge, Anjali Kumar, Raghbir Kaur, Disparities in Access to Oral Health Care, Annual Review of Public Health, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7125002/* (accessed March 20, 2023).

[11] Jo Henderson-Frost and Mark Deutchman, Eight Ways to Mitigate US Rural Health Inequity, *AMA Journal of Ethics, https://pubmed.ncbi.nlm.nih.gov/35133731/* (accessed March 20, 2023).

[12] Huabin Luo, Qiang Wu, Ronny A. Bell, Wanda G. Wright, Raul I. Garcia, and Sara A. Quandt, Trends in use of dental care provider types and services in the United States in 2000–

practice costs can disincentivize dentists from practicing in these areas because they can expect higher compensation rates when practicing in urban areas. As such, we urge Congress to provide tax credits for establishing and operating a dental practice in an underserved area.

Second, a significant amount of dentists operate as small business owners and employers. One study found that dental practices, experienced a 6 percent revenue decline in 2020 compared with 2019, with dental hygiene appointments alone dropping 47 percent.[13] This was largely a result of workforce shortages and layoffs, health and safety fears, foregone care, and other consequences experienced and exacerbated during the COVID–19 pandemic. Over the pandemic, the general cost of operating a dental practice also exponentially grew. For example, practices often spent a lot more to procure necessary personal protective equipment (PPE), such as masks and gloves, as those manufacturers experienced their own financial strains. It is critical to continue supporting private dental practices by avoiding any new specific tax on dental services[14] and by providing thorough tax incentives so dentists can provide the critical preventative and routine oral health care people need to protect their overall well-being.

Third, a health savings account (HSA) paired with an HSA-qualified health plan allows for tax-free contributions to a savings account. Funds from these accounts can be used to pay for qualified expenses, including most dental expenses. The AGD supports increasing the maximum allowable contributions to flexible spending accounts (FSA), health savings accounts (HSA), health reimbursement accounts (HRA) and also supports changes that would allow families to carry over FSA contributions from year to year.[15] Currently, carry-over is limited to HSAs and HRAs, which may further inhibit an individual's ability to seek and receive oral health care. Consumers participating in these tax-advantaged accounts can evaluate the spending of their health care dollars and make more informed decisions. Because dental benefit plans are so limited in their coverage, this is especially important to help finance oral health care needs.

III. Medicaid Policies

The AGD would also like to express its strong support of ensuring dental health benefits and access under Medicaid. Currently, between Medicaid, the Children's Health Insurance Program (CHIP), and private insurance, dental coverage for children has increased significantly since prior to the expansion of dental benefits in these programs. However, coverage does not necessarily translate to access to or utilization of care. Additionally, access to dental care for adults under Medicaid is significantly limited. For example, one study found that only 32 percent of those with public dental coverage reported dental care use in a given year.[16] Again, this reiterates the fact that coverage does not necessarily translate to utilization. We need to do more to increase access to dental services.

Further compounding this challenge is that dentists, and specifically general dentists, are not adequately reimbursed for providing services to Medicaid patients. Less than half of all dentists in the U.S. participate in Medicaid; this is not because they do not want to care for Medicaid patients, but rather, because they are unable to. Lagging reimbursement and administrative burdens are major factors. While reimbursement levels vary by state, they largely remain significantly lower than private payer reimbursements.[17] As previously mentioned, many dental practices are small businesses, and are forced to make business decisions to meet their overhead costs. Bringing the Medicaid reimbursement schedule closer to what traditional insurance pays will encourage more dentists to participate in the program. Addition-

---

2016: Rural-urban comparisons, *The Journal of the American Dental Association, https://www.sciencedirect.com/science/article/abs/pii/S0002817720303652* (accessed March 20, 2023).

[13] Gene Marks, Dentists Get Creative in Bid to Recover From COVID Downturn, *The Guardian, https://www.theguardian.com/business/2021/apr/22/dentists-creative-covid-downturn-vaccine-pandemic* (accessed March 20, 2023).

[14] The AGD supports the permanent repeal of the 2.3% medical device excise tax imposed by the Patient Protection and Affordable Care Act (ACA), Public Law 111–148.

[15] Stephen Miller, IRS Announces Spike in 2023 Limits for HSAs and High-Deductible Health Plans, SHRM, *https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/2023-irs-contribution-limits-for-hsas-and-high-deductibel-health-plans.aspx* (accessed March 20, 2023).

[16] Chad D. Meyerhoefer, Irina Panovska, and Richard J. Manski, Projections of Dental Care Use Through 2026: Preventive Care to Increase While Treatment Will Decline, *Health Affairs, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0833* (accessed March 20, 2023).

[17] Fontana, J., Lewis, C., Carver, T., Medicaid Adult Dental Reimbursement, Milliman, May 2019, *http://assets.milliman.com/ektron/medicaid-adult-dental-reimbursement.pdf https://catalyst.nejm.org/cause-crises-whole-health-whole-person/*.

ally, alleviating some of the regulatory and administrative burdens, such as prior authorization, associated with participating in the Medicaid program will also help more dentists participate.

Any expansion of present programs must address these barriers directly and be structured to enhance dentist participation. Efforts to address these barriers should include ensuring reasonable reimbursement for dentists and relief from administrative burdens. In particular, the AGD implores Congress to take steps to incentivize participation in government-funded dental care programs to achieve optimum oral health outcomes for indigent populations, including by raising Medicaid fees to at least the 75th percentile of dentists' actual costs. Additionally, the AGD encourages Congress to take steps to reduce the administrative burdens for dentists participating in Medicaid. This will help make certain that dentists are able to care for their Medicaid patients and advance the goal of providing comprehensive oral health care and preventative general dental care to all Americans.

IV. Medicare Policies

The elderly can be particularly at risk for oral health problems. The over 65 years-of-age population is diverse; their interests, resources and needs vary widely across the aging spectrum. Recognizing this diversity is key in terms of considering approaches to dental care. Considerations include treatment planning and increasing oral health literacy later in life.

However, the AGD opposes efforts to expand access by adding a dental benefit to Medicare.[18] The Medicare Part B program unfortunately cannot sustain the inclusion of dental benefits. The program itself is financially unstable and is approaching insolvency and beneficiaries should not have to rely on it for routine care, which is most dental care. Additionally, dental benefits are not insurance, because while insurance provides beneficiaries with policies that protect the insured for coverage of catastrophic events, dental benefits reduce the out-of-pocket costs for non-catastrophic costs. General dentistry care is primarily preventative. Dental benefit plans should thus be differentiated from insurance plans, as they are prepayment plans to be used by the beneficiary to the maximum extent each year to pay for routine dental care. However, Medicare enrollees may find that there is a need for industry to create new dental benefits products that would provide coverage for some of the more expensive and catastrophic dental services at a reasonable cost.

The AGD believes that any extra funds in federal insurance programs should instead be directed toward Medicaid. Currently, less than 50 percent of dentists participate in Medicaid due to low reimbursement rates. Increasing Medicaid reimbursement to industry standards will increase the number of dentists who participate in that program.

Additional Areas of Concern

The AGD would also like to highlight two additional priorities for this Congress: (1) improving oral health literacy and (2) addressing workforce challenges and concerns, including student debt.

I. Oral Health Literacy

Although outside the scope of this Committee's jurisdiction, the AGD appreciates Senator Cardin's efforts on the Oral Health Literacy and Awareness Act of 2023.

We strongly believe that by improving oral health literacy, we further everyone's access to dental health care, particularly among underrepresented populations and certainly including rural populations. Unfortunately, studies show that dental care visits declined drastically during the early phases of the COVID–19 pandemic, and although they have rebounded since, rates of dental care visits remain below pre-pandemic levels.[19] Studies also reflect large disparities among people who visit the dentist annually, disparities which were also exacerbated by the pandemic.[20] Fur-

---

[18] The AGD believes Medicare cannot sustain the inclusion of dental benefits. Market innovations should include the ability for seniors to obtain dental benefits in a competitive market, AGD Policy on Dental Benefits for the Medicare Population, *https://www.agd.org/dental-practice-advocacy-resources/advocacy-resources/key-federal-issues/medicare* (accessed March 20, 2023).

[19] Ashley M. Kranz, Annie Chen, Grace Gahlon, and Bradley D. Stein, 2020 Trends in Dental Office Visits During the COVID–19 Pandemic, *The Journal of the American Dental Association, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7942140/* (accessed March 20, 2023).

[20] As discussed above, people who are located in rural areas, have lower incomes, and are Hispanic and non-Hispanic Black, are less likely to have had a dental visit within the last year. Further, individuals living in rural or less economically advantages areas are less likely to have access to dental care.

ther, some populations require more regular or intense visits to their dentists but are unaware of the need to do so or the consequences of foregoing this care. For example, pregnant individuals may experience worse oral health due to hormonal fluctuations, and it is critical they see their dentist regularly to ensure any infection does not pass into the fetus. Other barriers to access and utilization that patients report include transportation issues, lack of oral health literacy,[21] fear, and/or anxiety. In summary, educating the public about the importance of maintaining good oral health should be a top concern—as oral disease left untreated can result in pain, disfigurement, loss of school and workdays, nutrition problems, expensive emergency room use for preventable dental conditions and even death.

II. Workforce

Additionally, the AGD deeply cares about issues related to workforce strains such as the student loan debt burden on its members. Without policies that support the dental workforce, dentists are unable to provide care for their patients. Thus, the AGD strongly supports policies that will help the current workforce as well as the pipeline of future workers, such as student loan forgiveness and workforce policies that will support staffing and operational needs of dental practices.

First, the AGD deeply cares about issues related to workforce strains and student loan debt burden on behalf of its members. For example, as seen in many of sectors in the health care industry and beyond, workforce strains among dentists were greatly exacerbated during the COVID–19 pandemic. Some practices had many of their employees quit during the pandemic due to the additional stress and fear resulting from the virus. Stressors and strains such as this on the workforce ultimately decreases people's access to oral health care and exacerbates the burden on dental practices.

Additionally, workforce strains were also accelerated due to the significant rates of mental health decline among all health care professionals, including dentists, during the COVID–19 pandemic. The stresses of dentistry in today's market results in an enormous mental load on dentists. Issues such as increasing student debt and private practice closures exacerbated the mental health challenges. Dentists also witnessed an increase in mental stress and illness in patients during the pandemic. For example, the incidence of cracked tooth syndrome among patients increased exponentially during the pandemic.

Further, the average dental school student graduates with over $286,000 in debt.[22] Most dental students rely on federal student loans to finance their education. With dental school tuition nearly doubling since 2000, new dentists are faced with staggering amounts of debt after graduation, which can limit their ability to choose a preferred career path. In addition, with the passage of the Budget Control Act of 2011, graduate students lost access to federally subsidized loans. Under this program, the federal government pays the interest while students are in school, during a grace period and during periods of deferment. The loss of this benefit has increased the debt burden on graduate and professional students, including dental students. As mentioned above, people living in rural and other underserved areas have significantly less access to dental care, but education costs can disincentive students from practicing in these areas after graduation. Thus, the AGD urges Congress to ensure education debt is not hindering diversity, restricting practice in underserved areas and/or serving as an outright deterrent for those wanting to enter the profession.

Conclusion

The AGD continues to advance its mission to promote and advance oral health for all by advocating for improved oral health literacy and a regulatory environment that supports general dentists' practice of primary oral health care. In conclusion, successfully advancing access to and delivery of oral health care to all Americans will require swift and intentional action. This action will need to support both the workforce, so they are able to care for patients across the U.S. no matter where they are located nor their ability to pay, and the patients, by educating them on the importance of healthy oral habits and expanding their access to care. Progress will require partnership across all stakeholders, including government and industry, and

[21] Oral health literacy is defined as the capacity to obtain, process, and understand basic health information and services needed to make appropriate oral health decisions. Healthy People 2010: Understanding and Improving Health. Washington, DC: U.S. Department of Health and Human Services; 2000.

[22] Melanie Hanson. Average Dental School Debt, Education Data Initiative, *https://educationdata.org/average-dental-school-debt* (accessed March 20, 2023).

we urge your support to ensure policies that prioritize oral health and well-being are elevated. The AGD strongly believes every person deserves a dental home and access to routine, safe, reliable, and quality oral health care.

Thank you for the opportunity to submit this statement for the Committee. We proudly offer to be a resource to this Committee and look forward to serving as a partner on oral health priorities.

LETTER SUBMITTED BY ANTOINETTE ALAIMO, BA, RDH, FMCHC

U.S. Senate
Committee on Finance
Subcommittee on Health Care
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Cardin,

It was exciting to listen in on the hearing regarding the oral health crisis.

I have been a Registered Dental Hygienist (RDH) for over 45 years! For many years, I practiced in Maryland, the District of Columbia and now Virginia. I had the privilege to work in Montgomery County, MD under Health and Human Services (HHS) for the Head Start program and low income 2nd grade—but lost my funding after 2 years, so I returned to the clinical setting. During my HHS period, I created a program for the 2nd grade, discussing the science of teeth that I am now turning into a book for 8–12 years old. (I could use funding—FYI) I was frustrated when Deamonte Driver died and will never forget his name.

I am now 67 years old, clinical hygiene is a struggle, so I was fortunate to receive the Volunteer position as the Dental Hygiene Liaison for Head Start for the state of Virginia! I am excited and have lots to do to improve the program, schools and educate the parents.

Here are my suggestions/thoughts regarding the oral health crisis that I hope you will be able to share with Mr. Wyden of Oregon and Ms. Warren of Massachusetts and others involved.

1. The RDH is a licensed oral health care provider. The RDH takes many continuing education courses (as many as a DDS/DMD) to maintain the license. The dental hygiene programs enable the graduate to be a specialist in the **PREVENTIVE wing of dentistry.** The Dental programs are more focused on RESTORATIVE. Both areas of dentistry are important—BUT—everyone needs Prevention! And sometime more then twice a year.
2. Currently, the dental hygienist is regulated by the Dental Boards in each state except California. Over 10 years ago, California created the first Dental Hygiene Boards. The RDH in California can graduate as a licensed RDH or get further certification to become an Advanced Practitioner-RDHAP. My suggestion is for Congress to support the American Dental Hygiene Associations in each state wishing to **create a Dental Hygiene Board for their state to allow the profession to grow and be guided by like-minded professionals.** Most allied health professions regulate their own industry—so this is not an unusual request. With the knowledge of statistics and the poor reports on oral health, access to care and care discrepancies, allowing the **RDH to self-regulate** would be a huge jump in access to care, direct payment to the RDH provider, creating a RDH career—not just a job (which most RDH's feel), eliminate the glass ceiling for the RDH, let the RDH who achieves Master's and PhD's in public health and dental hygiene know they will make a difference!
3. **It's not just a cleaning!** When you see a RDH, they are listening to all the questions and symptoms the patient may have, reviewing their health history, taking blood pressure, taking all necessary dental x-rays and reviewing them with the patient, perform an oral cancer head and neck screening, checking patient's occlusion—does the patient grind or clench their teeth? Would a night guard be beneficial, discuss resting position, do they have good airway? How is their sleep? Can they breathe through the nose? Explain bacteria that causes cavities and the bacteria that causes gum/periodontal disease which can lead to bacteria that causes heart disease, Alzheimer's disease, hormonal changes with pregnancy, how to take care of an infant's mouth and teeth and the need for a one year examination, educate on how fluoride and hydroxyapatite work to

remineralize enamel and ph of saliva, dry mouth situations and remedies, perform a dental cleaning using ultrasonic and hand scalers, discuss necessary treatments. What's biofilm, how do I use an electric toothbrush, waterpik and interdental cleaners? What is the best for the patient? And set up a recare appointment so they will return. This is **PREVENTION—THAT EVERYONE NEEDS**—before it becomes chronic or a crisis—we need a Preventive Care Act! What other job has one person doing all this? We need it to be a career with self-regulating boards and direct pay to the RDH—that is how more people will want to choose this career.

4. Teledentistry—so many RDHs would love to create a business to care for individuals in rural areas. It would be a dream to many to open their own mobile units and give preventive treatment. It's frustrating to see that nail salons are just licensed but regulate themselves! It's time for a change.
5. How did this happen? The DC health journalist, Mary Otto, wrote a book called "Teeth," after Deamonte died. Sadly, the dental and medical profession where once together, but became separated in the 1860s. The hygiene profession is 110 years old this year and was created by the dental industry. At that time, most dentists were white males and the hygienist where white females and housewives. It's certainly not that now! Many dentists are concerned that if the RDH is empowered that they will lose dollars. That is not true! More people will take the position as it will be a career with many avenues. And the RDH will be referring to the local DDS/DMD—a partnership between colleagues.
6. Education costs—it's many times more expensive to become a DDS/DMD then it is to become a RDH. And prevention is the key—that everyone needs. The RDH would gladly take a lower government payment for preventive care—American Dental Association fights the Medicare bill as they have higher costs and desires.
7. Research shows other organizations such as the PEW Group and Children's Hospitals and the general public would agree that access to care would improve if there were Dental Hygiene clinics, owned by RDH's and easily accessible to the public. There are so many people without basic preventive services that the RDH would be able to handle.
8. Nursing homes, schools and hospitals all need a dental hygienist on the staff. Why is this so foreign? The need is great and obvious. Every hospital needed a RDH during the pandemic and still does. Every school needs a RDH that they can contact (I oversaw 30 elementary schools in Montgomery County), and you know nursing homes or senior homes need preventive care.
9. Preventive care before restorative care is needed—is the key.
10. I can gladly get a team of RDH's from all over the USA to speak if that would help the cause. We are ready and able!

Thank you for reading this and I hope it influences your decisions. Please contact me with any questions or suggestions.

Sincerely,

Antoinette Alaimo

AMERICAN ASSOCIATION FOR DENTAL, ORAL, AND CRANIOFACIAL RESEARCH
1619 Duke Street
Alexandria, VA 22314–3406
T +1 703–548–0066
F +1 703–548–1883
https://www.aadocr.org/

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

The American Association for Dental, Oral, and Craniofacial Research (AADOCR) respectfully submits this statement as it pertains to the hearing "An Oral Health Crisis: Identifying and Addressing Health Disparities," which your committee held on March 29, 2023. We appreciate your consideration of our requests.

Oral health—too often considered in isolation—is integral to overall health. Poor oral health can affect activities that may be taken for granted—the ability to eat, drink, swallow, smile, speak, and maintain proper nutrition—and create economic burden that disproportionately harms older adults, low-income, and underserved communities.

The oral cavity serves as a window into many health issues, including but not limited to systemic diseases, such as diabetes, HIV/AIDS, and Sjögren's, an autoimmune disease that causes one's immune system to attack parts of its own body. Additionally, researchers are exploring the debilitating loss of salivary gland functioning and saliva production stemming from radiation treatment for head and neck cancers and even from common medications and aging itself. Lack or loss of saliva, which causes xerostomia, or uncomfortable dry mouth, has also been shown to be a risk factor for dental caries.

In December 2021, the National Institute of Dental and Craniofacial Research (NIDCR) released "Oral Health in America: Advances and Challenges", a data-driven report documenting 20 years of progress in oral health since the 2020 Surgeon General's Report on Oral Health. The report provides insight into issues currently affecting oral health and serves as a call to action to transform how the U.S. addresses oral health, including future NIDCR research, oral health promotion, disease treatments, and strategies to overcome health disparities for all Americans.

One of the key findings from the report was that oral and medical conditions share common risk factors. Oral health treatment can improve other health conditions and a person's health overall. However, vast inequities remain in access to oral health care and health outcomes related to race, ethnicity, residence, education, and socioeconomic level. According to the Kaiser Family Foundation, nearly 24 million Medicare beneficiaries lack critical oral health coverage, and 76.5 million adult Americans lack dental coverage overall.

The lack of dental coverage and access to services disproportionately impacts populations of color. For example, Black and Hispanic seniors in the U.S. have two to three times the rate of untreated cavities as older non-Hispanic white adults. The same disparities exist for low-income seniors and those without a high school degree. Both groups are about three times as likely to have untreated cavities as adults with higher incomes or at least some college education.

To help address these inequities, AADOCR supports the coverage of dental and oral health services under the Medicare and Medicaid programs. Chronic diseases such as diabetes, heart disease, chronic lung disease, dementia, and stroke have been shown to increase the pathogenicity of the oral microbiome, as shown by increased inflammation, periodontal bone loss, and increased risk or severity of periodontitis. Studies have discerned a relationship between oral bacteria, dental caries, periodontal diseases, and oral squamous cell carcinoma (OSCC).

The increased prevalence of several types of oral bacteria have also been shown to be positively correlated with the metastasis of malignant tumors. Early detection and treatment are appropriate strategies to prevent and control oral cancer and for an improvement in patient outcomes. Therefore, payment for the delivery of preventive dental care, and conservative periodontal treatment are key interventions to decrease the prevalence of malignant oral cancers.

Furthermore, periodontal disease has been shown to increase susceptibility to several systemic diseases due to shared risk factors, subgingival biofilms acting as reservoirs to gram negative bacteria, and through the periodontium acting as a reservoir of inflammatory mediators. The treatment of oral diseases can also impact systemic diseases including cardiovascular disease, infective endocarditis, bacteria pneumonia, diabetes mellitus and others. Treatment of periodontal disease has been shown to reduce by 65% the level of C-reactive protein—an inflammatory marker seen in myocardial infarction and stroke. Coverage of even routine dental services will reduce susceptibility to systemic diseases and improve outcomes of other covered medical services.

Oral diseases have been shown to preclude, delay, and even jeopardize medical treatments such as organ and stem cell transplantation, heart valve repair or replacement, cancer chemotherapies, placement of orthopedic prostheses, and management of autoimmune diseases. Despite these factors, most Medicare beneficiaries do not currently receive oral or dental care. In fact, Medicare coverage extends to the treatment of all microbial infections except for those relating to the teeth and periodontium. This exclusion has no medical justification, especially in light of the broad agreement among health care providers that such care is integral to the medical management of numerous diseases and medical conditions. Moreover, the lack of medically necessary oral/dental care heightens the risk of costly medical complications, increasing the financial burden on Medicare, beneficiaries, and taxpayers.

Researchers have discovered that oral diseases share many of the same behavioral and social determinants as other noncommunicable diseases such as diabetes and

hypertension, including tobacco use, environmental setting, unhealthy diets high in free sugars, and lack of access to health care, and these vulnerabilities accumulate along the life course and contribute to disparities in oral health outcomes.

The payment of preventative routine dental care by Medicare and Medicaid will help reduce barriers to oral health care and may bolster efforts to integrate oral health and primary health care, incorporate interventions at multiple levels to improve access to and quality of services, and create health care teams that provide patient-centered care in both safety net clinics and community settings across the life course. In addition, the payment of services for the treatment of oral diseases by Medicare and Medicaid will also improve oral-health-related quality of life (OHRQoL) across the life spectrum for persons within this socioeconomic demographic.

For these reasons, the Association strongly supports the Medicaid Dental Benefits Act (S. 570), legislation introduced and championed by Chairman Cardin. This measure is necessary to ensure comprehensive dental care is covered under Medicaid regardless of what state a patient lives in. The current patchwork of dental coverage offered by state Medicaid programs leaves millions of adults who rely on Medicaid for their health care without the access to dental care that they need. More than half of the states only offer limited dental benefits, emergency-only coverage, or no coverage at all for adults.

Adults who rely on Medicaid are also the least likely to access dental care given their financial constraints. Not only do they face the greatest cost barriers to dental care, they are more likely to experience dental pain and report poor oral health. Oral diseases not only cause pain, discomfort, social isolation, interruption of school and work, but also place undue strain on our health system and reduce economic productivity, leading to direct and indirect costs that are estimated to be as high as $2.7 billion annually.

AADOCR also supports the Medicare and Medicaid Dental, Vision, and Hearing Benefit Act (S. 842), legislation that would strengthen coverage for dental services under Medicare by repealing the statutory exclusion that restricts coverage of such services. The measure would expand Medicare coverage to ensure beneficiaries are covered for dental and oral care, including coverage of routine cleanings and exams, fillings and crowns, major services such as root canals and extractions, emergency dental care and other necessary services, and payment for dentures.

About half of Medicare enrollees report that they have not had a dental visit in the past year often related to the cost of care. Adding oral health coverage to Medicare Part B would allow an estimated 60 million older adults and people with disabilities to receive dental care, which would improve their overall health, lower health care costs, and increase their ability to keep their jobs.

We appreciate the opportunity to submit this statement and thank the Subcommittee for its support of enhanced access to dental and oral care. We stand ready to assist the members of this Subcommittee in any way we can and are happy to answer any questions you may have.

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

April 11, 2023

The Honorable Benjamin L. Cardin
Chairman
U.S. Senate
Committee on Finance
Subcommittee on Health Care
Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Steve Daines
Ranking Member
U.S. Senate
Committee on Finance
Subcommittee on Health Care
Dirksen Senate Office Bldg.
Washington, DC 20510

RE: An Oral Health Crisis: Identifying and Addressing Health Disparities

Dear Chair Cardin and Ranking Member Daines:

The American Network of Community Options and Resources (ANCOR) appreciates the opportunity to provide a statement for the record for the hearing, "An Oral Health Crisis: Identifying and Addressing Health Disparities."

Founded more than 50 years ago, ANCOR is a national, nonprofit association representing 2,000 private community providers of long-term supports and services to

people with intellectual and developmental disabilities (I/DD), as well as 56 state provider associations. Combined, our members support more than one million individuals with I/DD across their life span and are funded almost exclusively by Medicaid. Our mission is to advance the ability of our members to support people with I/DD to fully participate in their communities.

ANCOR is grateful for the work of the subcommittee in highlighting the need for better accessibility of oral health care for people with disabilities. Disparities in access to and coverage of dental care for people with disabilities is a problem that jeopardizes individuals' overall health and undermines Medicaid's goal of ensuring equity for all.

Across the country, Medicaid is the largest payor of supports and services for people with disabilities, covering various essential services such as medical care, long-term supports in home and community-based settings, and employment programs. However, one of the largest gaps in coverage for adults with disabilities is the coverage of comprehensive dental services under state Medicaid programs. As Dr. Brill rightly noted in his testimony, "dental decay is not an equal opportunity disease," but it impacts people with disabilities in higher rates, "compromis[ing] the health, development, and quality of life" of those individuals. Given the importance of comprehensive dental care to treat and prevent dental decay and other forms of oral disease, the lack of coverage among states is highly problematic.

According to a 2021 survey of state Medicaid adult dental services coverage conducted by the Medicaid and CHIP Payment and Access Commission, while most states provide some form of dental coverage, three states provide no adult dental benefit at all, and nine states cover only emergency services.[1] This lack of full coverage is particularly troubling given that states may further reduce or eliminate dental benefits during a budget shortfall, which could have a severe impact on the health and well-being of people living in states with already limited coverage.

ANCOR supports the Medicaid Dental Benefit Act of 2023, introduced by Chair Cardin, which would improve the coverage of dental and oral health services for adults covered by Medicaid. We also appreciate the creation of a core set of adult oral health quality and equity measures, which will provide necessary data to ensure individuals are receiving the care they need and identify gaps in accessibility.

In addition to the lack of adequate coverage for dental care under state Medicaid programs, another hurdle to accessing comprehensive dental care for people with I/DD is the lack of providers. Even for those living in states with Medicaid coverage of services, there are low levels of dentist participation in Medicaid. According to a 2021 survey by the American Dental Association, only one out of three dentists sees at least one Medicaid patient in the course of a year, with just 18% of dentists seeing at least 100 Medicaid patients per year.[2]

There are many factors affecting provider participation in Medicaid, including low reimbursement rates.[3] For many dental providers, a barrier to participation is the lack of education and adequate training on how to best assist individuals with I/DD. ANCOR supports measures to improve education and training for dental providers, including support for partnerships among providers of dental care, health care, and long-term supports and services.

Thank you for highlighting the importance of better accessibility to dental care and for the opportunity to submit a statement for the record. ANCOR supports the work of this subcommittee to improve access to and coverage of dental care and looks forward to the opportunity to work with members on this issue. For questions or more information, please reach out to Elise Aguilar, Director of Federal Relations, at eaguilar@ancor.org.

Sincerely,

Elise Aguilar
Director of Federal Relations

---

[1] Medicaid and CHIP Payment and Access Commission, Medicaid Coverage of Adult Dental Services (January 2021), *https://www.macpac.gov/publication/medicaid-coverage-of-adult-dental-services/*.

[2] Marko Vujicic, et al., Dentist Participation in Medicaid: How Should It Be Measured? Does It Matter?, Health Policy Institute (October 2021), *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf*.

[3] Niodita Gupta, et al., Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for All States, Health Policy Institute (April 2017), *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0417_1.*

AMERICAN NETWORK OF ORAL HEALTH COALITIONS
P.O. Box 4567
Topeka, KS 66604
(724) 961–6057

Statement of Helen Hawkey, Board Chair

On behalf of the American Network of Oral Health Coalitions (ANOHC), I want to thank Chairman Cardin and Ranking Member Daines for holding this important and timely hearing, and offer my sincere appreciation to all of the witnesses and committee members who spoke about the impact of oral health inequities on socio-economic advancement, self-esteem, and overall health and diseases prevention of Americans. ANOHC is a national voice for state oral health coalitions and their members, dedicated to improving oral health care access and overall health.

Since the founding of dental schools as institutions distinct from medical schools, dentistry—its practice, service delivery, and insurance coverage, for example—has remained separate from medical care in the United States. This separation is particularly detrimental to persons living in poverty, the elderly and persons living with disabilities—the groups at highest risk for poor oral health because they are least able to afford costly services without financial assistance and the least able to travel to areas where providers are available.

It is time to solve the problem and truly address the inequities for America's families. ANOHC believes Congress should take immediate action to insure that every American has an equal opportunity to a healthy mouth.

As advocates for the oral health community, ANOHC recognizes the need for improved dental coverage in Medicaid and Medicare. Without this coverage, millions of older adults, people with disabilities, and low-income families in our nation cannot afford the care they need to get and stay healthy. ANOHC also supports increased funding for oral health education and training programs to ease the strain on current providers and expand access in underserved areas. To truly impact oral health disparities at the state and local level, ANOHC calls on the federal government to allocate funding to support state oral health programs.

The Impact of Oral Health

Oral health is essential to general health and well-being at every stage of life. A healthy mouth enables not only nutrition of the physical body, but also enhances social interaction and promotes self-esteem and feelings of well-being. The mouth serves as a "window" to the rest of the body, providing signals of general health disorders. Oral conditions have an impact on overall health and disease. Bacteria from the mouth can cause infection in other parts of the body when the immune system has been compromised by disease or medical treatments (*e.g.,* infective endocarditis). Systemic conditions and their treatment are also known to impact oral health (*e.g.,* reduced saliva flow, altered balance of oral microorganisms). Today, oral health access continues to discriminate against immigrants, low-income families, rural communities, people with disabilities, and unemployed or underemployed.

Oral health affects a person's overall health, income, and quality of life. Yet, the dental care delivery system remains divorced from the rest of the healthcare system. The notion of dentistry as a field separate from medicine is a historical phenomenon that has been reinforced through legislation, education, and service delivery. This division places an undue burden of dental disease on the most vulnerable Americans who face barriers to accessing dental care.

State Remedies are Limited without Action by Congress

Access to dental care is not equitable for all; certain populations face barriers when trying to access dental services. These barriers can include geographic location, lack of insurance or inadequate insurance coverage, disability status, income, and more. States are doing everything in their power to address oral health inequities. From creative workforce solutions such as dental therapists and direct access hygienists, to nonprofit dental clinics, to one-day free dental clinics such as Mission of Mercy, states are doing their very best to care for those who are left behind.

All states are facing a twin challenge with the dental workforce—the aging of dental professionals and the ongoing effects of the COVID–19 pandemic. As older dentists retire, there is a shortage of qualified providers to fill their positions, particularly in rural or underserved areas. The pandemic also created financial and operational challenges for many dental practices, reducing their capacity to see patients or forcing them to close altogether. These factors further contribute to disparities in access to dental care.

Solutions

Addressing health disparities must be the goal of all stakeholders involved in oral health but it is impossible to create equitable systems without a solid foundation. This foundation must include an adequate supply of providers in the state and resources to develop actionable, state-level data along with staff to create effective strategies. ANOHC propose several solutions that can establish environments in states to that allow for the development of policies to address oral health disparities:

1. **Require comprehensive dental coverage in Medicare and Medicaid at the federal level.**

Improving dental coverage through Medicare and Medicaid means people can better afford dental services. When people can afford services, providers can keep their doors open, increasing the number of providers that can participate in networks. When people can afford preventive care and early treatment of disease, they are less likely to experience severe oral health problems that require costly emergency treatment. Additionally, improved oral health can have positive impacts on overall health and reduce costs for medical care.

2. **Increase federal investment in dental education and workforce development programs.**

Expanding the supply of oral health professionals is necessary in an environment where access is constrained in many areas. Networks are already strained with reduced staff after COVID, retiring professionals and increased demand for services. States can't do this alone. They will require funding and assistance to achieve an adequate number of trained providers to serve all populations.

3. **Provide all states with oral health program funding.**

Challenges faced by states in oral health are similar but also unique. Similar in that all states are experiencing workforce shortages exacerbated by COVID that is increasing oral health disparities that were often profound before the pandemic. However, the strategies each state will need to develop and deploy to address the challenge is unique and dependent on how oral health is financed, demographics, availability of higher education and training, geography, data collection capabilities and many other factors. Providing each state with funding directly to their state-level oral health program will provide a foundation for the development of programs and strategies to meet the challenge each state faces.

Thank you for your time and consideration of this worthwhile topic. As the most common chronic disease of children and adults across the nation, an investment in this subject benefits us all.

CALIFORNIA PAN-ETHNIC HEALTH NETWORK
1221 Preservation Park Way, Suite 200
Oakland, CA 94612
(510) 832–1160 phone
https://cpehn.org/about-us/contact-us/

April 10, 2023

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

RE: Wednesday March 29, 2023 Subcommittee Hearing on Oral Health Crisis

Dear Senate Committee on Finance:

The California Pan-Ethnic Health Network is writing to applaud lawmakers' recent push to expand oral health coverage for Americans in the recent subcommittee hearing on the oral health crisis. For far too long, Americans have suffered the consequences of poor oral health care, including chronic disease, chronic pain, difficulties obtaining employment, and school absences, across the country.[1] These consequences have been disproportionately shouldered by marginalized communities. Congress should act to prevent the disproportionate impact of poor oral health care

[1] "The Many Costs (Financial and Well-Being) of Poor Oral Health," University of Illinois Chicago, accessed August 31, 2022, *https://dentistry.uic.edu/news-stories/the-many-costs-financial-and-well-being-of-poor-oral-health/*.

on marginalized communities by passing and implementing the Medicaid Dental Benefit Act (S. 570/H.R. 1342).

CPEHN is a statewide multicultural health advocacy organization dedicated to the advancement of health justice through racial equity. Since 1992, CPEHN has served California's Black, Indigenous, Communities of Color (BIPOC) by bringing together and mobilizing historically excluded populations to advocate for public policies that advance health equity and improve health outcomes. We are the backbone for the California Oral Health Progress and Equity Network (CA–OPEN), which gathers the collective power of diverse voices to ensure oral health is a fundamental right for all Californians. We supported earlier efforts to make the Medicaid dental benefit a permanent one.

Establishing permanent, comprehensive oral health coverage for all adults who rely on Medicaid will advance health, economic, and racial justice on a national scale. Among adults with low incomes in California, almost 50% of Latino adults did not have dental insurance in 2020, compared to 28% of White adults with low incomes.[2] Adults who did not have dental insurance were also about 3 times more likely to have no natural teeth compared to adults who did have dental insurance.[3] To address these oral health disparities and advance oral health equity, S. 570/H.R. 1342 will:

1. Require coverage of oral health services for adults under the Medicaid program.
2. Require adult oral health quality and equity measures.
3. Require an adult oral health care report.
4. Require oral health outreach and education.

CPEHN's research in California has found that the lack of stable preventive and restorative dental coverage is one of the most significant barriers to accessing oral health care for low-income communities.[4] While California currently has comprehensive adult dental benefits for adults enrolled in Medicaid, this has not always been the case. In the last 15 years, California has eliminated and restored dental benefits for millions of adult recipients of Medicaid multiple times. In 2017, CPEHN and its grassroots partners successfully mobilized our communities to advocate for the full restoration of adult dental benefits. In 2019, we again successfully mobilized over 100 organizations, including dental providers, advocates, universities, and community groups to prevent cuts to the fully restored adult dental benefits as a result of the unprecedented impact of COVID–19 on our economy. Oral health coverage, however, should be a *permanent* adult Medicaid benefit that is no longer subject to the volatility of the state budget.

As a result of these previous budget cuts, California's oral health system remains fragile. The year-to-year changes in coverage have caused many providers enrolled in Medicaid to leave the program,[5] reducing the already low number of providers who accept Medicaid, leaving Medicaid members with less options to receive oral health treatment. Additionally, the year-to-year changes have caused great confusion among Medicaid members who are affected by these sudden policy changes and left wondering whether or not they will have access to a dental check-up in a given year. Changes to dental benefits for adults enrolled in Medicaid also lead to the inability to continue ongoing treatment, interruptions in access to preventive services, and expanded use of the emergency room for preventable dental conditions. Overall utilization rates remain low, with statewide utilization rates growing by only one to two percent across all service categories (annual dental visits, preventative services, dental exams, diagnostic services, and dental treatments).

Medicaid members' oral health needs will only grow exponentially in the post-COVID–19 period. Over 25% of dental practices in California closed after statewide

---

[2] UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2020. Dental Insurance—Adult Compared by Race, UCLA CHPR, limited by FPL 0–138%, age 21–64.

[3] UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2019. Condition of Teeth—Adults Compared by Dental Insurance—Adult.

[4] "Addressing the Root: Dismantling Systemic Barriers to Oral Health Equity," September 30, 2022, *https://cpehn.org/assets/uploads/2022/09/CPEHN.OralHealthReport.Proof_.16390.V4.pdf.*

[5] Ron Shinkman, "Number of Dentists Who Accept Denti-Cal Declined over Last Five Years," *The Mercury News,* April 10, 2018, *https://www.mercurynews.com/2018/04/10/number-of-dentists-who-accept-denti-cal-declined-over-last-five-years/*.

safer-at-home orders.[6] Although California issued guidelines[7] to help health care providers return to practice—an effort to begin the process of resuming non-emergency, non-COVID–19 health care services—the state should not overlook the oral health care long-term consequences resulting from pandemic fears around accessing dental care by both providers and members. Millions of Medicaid members, many of whom postponed both routine and necessary care, will need to pursue or continue treatment. Permanent adult oral health coverage will be essential to ensuring Medicaid members receive the oral health care they will unquestionably need.

Americans should not have to worry about their access to dental care changing from year to year simply because they are enrolled in Medicaid. S. 570/H.R. 1342 will help address the challenges highlighted in this letter, and improve the overall health of all Americans. For these reasons, we urge Congress to act on the Subcommittee Hearing on Oral Health Crisis' findings by passing the Medicaid Dental Benefit Act (S. 570/H.R. 1342). If you have questions about this statement for record, please contact Carolina Valle at cvalle@cpehn.org.

Sincerely,

Carolina Valle

COMMUNITY CATALYST
One Federal Street, 5th Floor
Boston, MA 02110
https://communitycatalyst.org/

April 7, 2023

The Honorable Benjamin L. Cardin
Chairman
U.S. Senate
Committee on Finance
Subcommittee on Health Care

The Honorable Steve Daines
Ranking Member
U.S. Senate
Committee on Finance
Subcommittee on Health Care

Dear Chairman Cardin and Ranking Member Daines:

Community Catalyst is pleased to submit a statement in regards to the Subcommittee's recent hearing on oral health disparities.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and healthcare are made: in communities, state houses, and on Capitol Hill. We share your goals of making the healthcare system work for those not currently well-served, especially people of color, individuals with low incomes, rural communities, and older adults, and appreciate your attention to the important role of the dental care system.

We appreciate the subcommittee's recognition of the limits of the current optional nature of Medicaid dental benefits for adults and the impact on older adults and people with disabilities of the current lack of comprehensive dental benefits in Medicare. We also appreciate your attention to the need to strengthen and support the dental workforce, including increasing the number of providers, diversifying the workforce, and expanding the use of teledentistry to increase the reach of the system.

Improving Public and Private Dental Coverage

Dental care presents the greatest financial barriers[1] of any healthcare service—nearly 40% of dental care costs are paid out of pocket[2] and almost half of adults identify cost as a barrier to getting care.[3] As noted during the hearing, many states have very limited coverage of dental care for adults in their Medicaid programs and Medicare does not include any dental benefits. Adult dental care is also absent in

---

[6] *https://surveys.ada.org/reports/RC/public/.*
[7] *https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID19/ResumingCalifornia%E2%80%99sDeferredandPreventiveHealthCare.aspx.*
[1] *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0800.*
[2] *https://www.chcf.org/publication/us-health-care-spending-who-pays/.*
[3] *https://www.carequest.org/SOHEA2022.*

the Essential Health Benefits (EHB) package that many health plans must follow. As a result, access to dental care for people with Medicaid, Medicare, and private insurance remains inconsistent and woeful. The availability and comprehensiveness of optional adult dental benefits in Medicaid varies widely from state to state and fewer than half of dentists accept Medicaid[4] at all, leaving many families without access to care even if they do have coverage. Similarly, about half of people with Medicare have no dental coverage[5] and the same amount do not get a yearly dental visit.

Unsurprisingly, this patchwork of coverage and access often results in dental debt, which contributes to broader medical debt for about half of adults[6] who incur it. Due to structural racism and resultant longstanding economic inequities, people of color are more likely to have debt as a result of dental or other medical bills and face greater barriers to accessing dental care in general. Additionally, as Dr. Marko Vujicic noted in his testimony, about one-third of low-income adults say that dental conditions limit their job prospects.[7]

The benefits of standardizing dental benefits for adults are far-reaching. As Dr. Vujicic also noted, lack of dental coverage can result in unnecessary emergency department (ED) use for dental problems. When people don't have access to the care they need, they often wait until dental problems become so painful that the ED is their only option. ED's are typically not set up to provide adequate treatment and most people leave with only antibiotic and painkiller prescriptions. In addition to not providing the dental care people need, these visits cost the health care system more than $2 billion a year.[8] This costly, unnecessary, and ineffective problem can be solved by **making comprehensive adult dental benefits a mandatory coverage category in state Medicaid programs and including them as part of the EHB package.** Mandating adult dental benefits in Medicaid would save at least $273 million per year[9] on the medical side.

Additionally, as the testimonies of Dr. Warren A. Brill and Dr. Farmer-Dixon highlighted, adult dental coverage, including during pregnancy, can have cascading effects on children's oral health—research shows that Medicaid adult dental coverage is associated with decreased dental disease in children.[10] Comprehensive adult dental care can have a positive impact on the oral health of whole families.

Finally, as Dr. Vujicic noted, while some Medicare Advantage plans optionally cover dental care, few Medicare beneficiaries actually use it due to high cost sharing. And, as Dr. Farmer-Dixon noted, people are less likely to get the care they need when out-of-pocket costs are high. **Including a comprehensive dental benefit in traditional Medicare could ultimately result in cost savings** as a result of fewer unnecessary ED visits, reduction in overpayments and other administrative burdens, and medical-side savings.

Finally, we appreciate Dr. Brill's testimony on the need for education for parents and the public about the importance of oral health. We support efforts to equip communities with the information and resources they need to understand their oral health, the services available to them, and to advocate for themselves and their families. Data show that the vast majority of people understand the importance of oral health and its connection to overall health.[11] **To fully address our nation's oral health crisis, we need policy solutions to improve dental coverage and ensure providers are available to serve communities.**

Expanding and Diversifying the Oral Health Workforce

We further appreciate the subcommittee's recognition of the need to continue to strengthen our nation's oral health workforce to ensure equitable access to high-quality and culturally respectful care for every person, especially in rural, low-income, and communities of color. More than 70 million people live in areas without

---

[4] *https://www.ada.org/resources/research/health-policy-institute/dental-care-market#:~:text=As%20of%202019%2C%20approximately%2043,state%20in%20which%20they%20practice.*

[5] *https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/.*

[6] *https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/.*

[7] *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf.*

[8] *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf.*

[9] *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/whitepaper_0721.pdf.*

[10] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8609949/.*

[11] *https://www.carequest.org/SOHEA2022.*

enough dental providers [12] and rural and low-income communities are most likely to be impacted. The low number of dentists who are people of color—who are more likely to practice in underserved areas—also likely means that the dentist-to-population ratio in communities of color is lower.[13]

Like many other measures of health, racial disparities in access to dental providers continue to exist. However, beyond simply increasing the number of providers in underserved communities, we must also strive to establish a health care workforce that is community based and more representative of individuals in these communities. Increasing the diversity of health care providers and fostering a community-centered workforce has long been a key recommendation for addressing racial and ethnic health disparities.[14] As Dr. Farmer-Dixon underscored in her testimony, we agree that **increasing dental provider diversity is critical to expanding access, improving oral health, and addressing disparities.**

A more diverse healthcare workforce can help address disparities in access to care.[15] When people of color have a provider of their same race, ethnicity, or culture, patient satisfaction and quality of care improve.[16] Despite strong evidence that racial concordance between providers and patients improves quality of care and reduces costly adverse outcomes, currently, the dental workforce is not representative of the communities it serves. Nearly three-quarters of dentists are white, and Black and American Indian and Alaska Native (AI/AN) people are particularly underrepresented in dentistry. Additionally, white dentists are the least likely to serve people with Medicaid. Dentists who are people of color are more likely to do so and are also more likely to work in underserved communities.[17]

We are supportive of the recommendations made to the subcommittee by experts like Dr. Farmer-Dixon to establish a more diverse pipeline of dental professionals. **We encourage the subcommittee to consider how community-driven provider models like dental therapists can help address access barriers, reduce oral health disparities, and establish a more representative and culturally respectful oral health workforce.**

In particular, evidence of the success of dental therapists has shown that these community-based providers improve access to dental care and oral health outcomes [18] at the population level. Dental therapists [19] are licensed providers who play a similar role in dentistry to that of physician assistants in medicine. They work under the supervision of a dentist to provide routine dental care like exams and fillings. Using teledentistry methods to collaborate with their supervising dentist, dental therapists can bring care to people where they are, including schools, nursing homes and rural communities. And because their employment cost is, on average, one-third to one-half the amount of a dentist, hiring dental therapists is a cost-effective way for safety-net clinics to stretch their budget to treat more patients. Currently, dental therapists are authorized to work in at least some settings in 13 states.

Recent recommendations from the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry [20] offer several opportunities to support and expand the oral health workforce through dental therapy, including updating Title VII training programs to explicitly include dental therapy programs and trainees, dedicating funding in Title VII specifically for dental therapy education programs, ensuring that dental therapy faculty are eligible for faculty loan repayment, and including dental therapists in the National Health Service Corps.

In rural communities, communities of color, and Tribal communities, dental therapy creates an accessible pathway for people from areas with little access to oral health care to become the dental providers their communities need. For the first time, these communities are gaining regular access to dental care from someone who is part of their community—who speaks their language, understand their culture, and can provide culturally respectful care that is grounded in shared experience.

---

[12] *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*
[13] *https://onlinelibrary.wiley.com/doi/10.1111/jphd.12501.*
[14] *https://www.ncbi.nlm.nih.gov/books/NBK220358/.*
[15] *https://pubmed.ncbi.nlm.nih.gov/25009857/.*
[16] *https://www.commonwealthfund.org/publications/fund-reports/2004/jul/disparities-patient-experiences-health-care-processes-and.*
[17] *https://journals.sagepub.com/doi/full/10.1177/10775587221108751.*
[18] *https://onlinelibrary.wiley.com/doi/abs/10.1111/jphd.12263.*
[19] *https://www.dentaltherapy.org/about/about-dental-therapy.*
[20] *https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/primarycare-dentist/reports/actpcmd-19th-report-dental-therapy.pdf.*

Oral Health Workforce and Innovative Technologies

In addition to expanding the dental workforce, we recognize the issues raised by Dr. Brill's testimony about the lack of operating room space for critical dental procedures. We support opportunities to improve access to dental care across a variety of settings to ensure a robust and comprehensive system that can serve the diverse needs of diverse patients. At the same time, with good access to preventive and basic restorative care, the need for dental surgery can be greatly reduced, avoiding unnecessary pain and invasive care and reducing the overall cost of care to both the patient and the healthcare system. Dental therapists are trained in the most commonly needed procedures in underserved communities and are well trained to provide preventive and basic restorative care needed to avoid more painful and costly care in the future. Often, they are trusted members of the communities they serve. They are shown to reduce extractions in both children and adults and can temper the need for pediatric dental care under anesthesia.[21] Dental therapists work closely with dental hygienists, who are experts in prevention, and are a critical part of the dental team's work to improve access and reduce disparities.

A fully staffed dental team can also make use of the most current technology to improve both access and outcomes. The use of teledentistry technology spread rapidly during the COVID public health emergency (PHE). As the PHE unwinds, many states have begun extending teledentistry policies in recognition of their impact on access to care and the fact that many barriers that teledentistry can address—including transportation, child care, and location of dental facilities—will continue to exist beyond the COVID era.

Additionally, in recent years, less invasive alternatives to drilling and filling cavities have become more commonplace in dentistry. Often referred to as "minimally-invasive dental care"[22] (MIC) these alternatives are used to catch and treat oral health problems early on, rather than waiting for disease to get bad enough for someone to need surgical or other more invasive interventions. Scientific advancement and the body of evidence around the effectiveness of MIC have grown rapidly, offering options for preventive and basic restorative care that are less expensive and traumatic for patients and can reduce systems costs in the long run.[23]

One medicine in particular, silver diamine fluoride (SDF), has shown promise in reducing disease and improving oral health for children and adults. The American Dental Association (ADA) and the World Health Organization (WHO) have recommended the use of SDF to stop the spread of existing cavities, prevent new ones, and even reverse decay.[24] It is simple and inexpensive to apply, and can easily be provided by dentists, dental therapists, dental hygienists, or non-clinical providers in community-based settings. These factors, and its low cost, provide opportunities to address financial barriers to oral health care and income-based inequities. In 2022, the American Medical Association (AMA) added a billing code to facilitate medical providers to administer SDF,[25] offering opportunities to foster medical-dental integration, to further expand the reach of critical dental care, and to advance oral health equity.

We greatly appreciate the subcommittee's attention to disparities in access to dental care and for seeking to address our nation's oral health crisis. We are eager to work with you to identify additional opportunities to support improvements to public and private dental coverage and diversification and expansion of our nation's oral health workforce through community-driven provider models. For additional information or questions, please contact Colin Reusch at creusch@communitycatalyst.org.

Sincerely,

Emily Stewart
Executive Director

---

[21] *https://onlinelibrary.wiley.com/doi/abs/10.1111/jphd.12263.*
[22] *https://communitycatalyst.org/resource/minimally-invasive-care/.*
[23] *https://journals.sagepub.com/doi/pdf/10.1177/0022034518800014.*
[24] *https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/silver-diamine-fluoride.*
[25] *https://www.carequest.org/about/blog-post/cpt-code-application-silver-diamine-fluoride-explained.*

DELTA DENTAL INSTITUTE
901 New York Avenue, NW, Suite 310W
Washington, DC 20001
https://www.deltadentalinstitute.com/

Statement of Vivian Vasallo, Executive Director

On behalf of the Delta Dental Institute, thank you, Chairman Cardin and Ranking Member Daines, for the opportunity to share insights following last week's hearing: "An Oral Health Crisis: Identifying and Addressing Health Disparities." We applaud you for holding a hearing to discuss this important issue and appreciate your willingness to allow additional stakeholders to submit statements for the record.

My name is Vivian Vasallo, executive director of the Delta Dental Institute. In this role, I head Delta Dental's work to elevate oral health in the nation's broader health care conversation through research, community engagement, and advocacy. In partnership with Delta Dental companies, we strive to ensure that everyone understands the importance of oral health to overall health and has access to the high-quality dental care they need.

Oral Health Is Integral to Overall Health

In 2000, the U.S. Surgeon General released a report[1] on oral health characterizing oral disease as a "silent epidemic" affecting vulnerable populations, including historically underrepresented groups, people with disabilities, and the elderly. Even 20 years later, research[2] shows that rates of tooth decay, periodontal disease, and oral cancers are far higher—and dental care utilization rates considerably lower—for historically underrepresented groups in the U.S. To adequately address disparities in oral health care, the Delta Dental Institute recommends the subcommittee focus on efforts to increase access to care, improve oral health literacy, and create a more diverse oral health workforce.

Oral health is critical to overall health, and poor oral health can have dangerous consequences. Oral disease is associated with cardiovascular disease,[3] respiratory disease[4] and adverse pregnancy outcomes.[5] Periodontal, or gum, disease is strongly associated with increased risk of cancer[6] and chronic diseases such as diabetes.[7] Untreated, often preventable, oral diseases send 2.1 million Americans[8] to the emergency room each year.

A poll[9] from the Delta Dental Institute shows Americans overwhelmingly agree that oral health is critical to overall health. In fact, more than two-thirds[10] agree the benefits of a routine dentist appointment during COVID–19 outweighed the potential risks of delaying preventive care. Yet there is a lot of work left to do to ensure all Americans have affordable access to the oral health care they need. Millions[11] of Americans lack dental insurance, and racial inequities have created stark gaps[12] in oral health outcomes for communities of color.

Prioritizing Oral Health

Americans want the federal government to take action to expand oral health access and affordability. Another Delta Dental Institute poll[13] found clear bipartisan support for improved access to oral health care, with 93% of Democrats and 80% of Republicans in support of dental coverage in Medicare, and 86% of Democrats and 66% of Republicans supporting state-based Medicaid coverage for oral health.

---

[1] *https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf.*
[2] *https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.303747.*
[3] *https://www.health.harvard.edu/diseases-and-conditions/gum-disease-and-the-connection-to-heart-disease.*
[4] *https://www.thoracic.org/patients/patient-resources/resources/dental-health.pdf.*
[5] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144105/#:~:text=Pregnant%20women%20with%20periodontal%20disease,prematurity%20and%20other%20adverse%20outcomes.*
[6] *https://www.sciencedaily.com/releases/2020/07/200720190919.htm.*
[7] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3228943/.*
[8] *https://www.ada.org/~/media/ADA/Public Programs/Files/HPRCBrief_0413_4.pdf?la=en.*
[9] *https://www.deltadentalinstitute.com/news/press-releases/consumers-believe-maintaining-good-oral-health-is-essential-to-protecting-overall-health-during-the-pandemic/.*
[10] *https://www.deltadentalinstitute.com/news/press-releases/new-poll-finds-americans-are-prioritizing-their-oral-health-during-covid-19/.*
[11] *https://www.nadp.org/Dental_Benefits_Basics/Dental_BB_1.aspx#:~:text=Some%2074%20million%20Americans%20had,even%20with%20dental%20coverage%20expansions.*
[12] *https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm.*
[13] *https://www.deltadentalinstitute.com/news/press-releases/new-survey-indicates-that-almost-half-of-us-adults-cite-inflation-among-top-concerns-for-delaying-or-canceling-dental-cleanings/.*

In addition to prioritizing oral health care access, to address oral health disparities and ensure the effectiveness of executive, legislative, or regulatory action related to oral health care, America needs more oral health experts in the federal government, including agencies like HRSA,[14] the CDC, and the Department of Veterans Affairs,[15] which have a substantial impact on Americans' oral health, but few have a chief dental officer or equivalent on staff. We commend[16] the Biden Administration and Centers for Medicare ad Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure for prioritizing oral health with their appointment of Dr. Natalia Chalmers as Chief Dental Officer, but there is still much work to be done.

Oral Health Literacy

Oral health literacy plays a critical role in driving health outcomes by enabling patients to make informed decisions about their care. In a Delta Dental Institute white paper, "Improving America's Oral Health Literacy,"[17] the authors found that while the public recognized the connection between oral and overall health, discrepancies in oral health outcomes remain, due in part to low levels of oral health literacy. Though survey results from a Delta Dental Institute poll found that most Americans feel generally positive about their ability to understand health information, there are gaps for low-income, aging, and rural communities that are important for all stakeholders, including dental health professionals, insurers, health funders, employers, and others, to address.

We applaud[18] the bipartisan introduction of the Oral Health Literacy Act (H.R. 994,[19] S. 403[20]), which would authorize a public education campaign across all relevant federal programs to increase oral health literacy and awareness. We believe this legislation will help create more equitable policies and initiatives for oral health and improve access to care. As such, we urge quick action in Congress to help close the oral health literacy gap.

Diversity in the Oral Health Workforce

While racial and ethnic diversity among health professionals is linked to improved outcomes and greater health equity, the current oral health workforce does not reflect the changing demographics of the U.S. population.

To help address this imbalance, on World Oral Health Day, March 20, 2023, Delta Dental launched the Driving Greater Diversity in the Oral Health Workforce Campaign[21] which will support workforce diversity initiatives through oral health education, literacy, research, and community investment, and by establishing the industry-leading Delta Dental Oral Health Diversity Fund.[22] In its first year, the Delta Dental Oral Health Diversity Fund will make targeted investments of up to $1 million to support innovative solutions and address barriers that school-aged children from historically underrepresented communities face in pursuing careers in the oral health professions.

In addition, recent research[23] from the Harvard School of Dental Medicine, sponsored by the Delta Dental Institute, found that expanding the dental workforce in Oral Health Professional Shortage Areas through the National Health Service Corps would reduce the risk of dental caries among children in underserved areas, improve care, and cut costs.

To further address oral health disparities, Delta Dental is committed to advancing diversity, equity, and inclusion and addressing the needs of diverse communities

---

[14] *https://www.hrsa.gov/oral-health.*
[15] *https://www.va.gov/dental/.*
[16] *https://www.deltadentalinstitute.com/news/press-releases/delta-dental-institute-applauds-new-cms-cdo/.*
[17] *https://www.deltadental.com/content/dam/delta-dental-policy/pdf/Formatted%20Oral%20Health%20Literacy%20White%20Paper%20vF.pdf.*
[18] *https://www.deltadentalinstitute.com/news/press-releases/delta-dental-statement-on-the-oral-health-literacy-act/.*
[19] *https://www.congress.gov/bill/118th-congress/house-bill/994?q=%7B%22search%22%3A%5B%22 oral%22%2C%22health%22%2C%22literacy%22%2C%22and%22%2C%22awareness%22%2C%22act%22%5D%7D&s=1&r=1.*
[20] *https://www.congress.gov/bill/118th-congress/senate-bill/403?q=%7B%22search%22%3A%5B%22 oral%22%2C%22health%22%2C%22literacy%22%2C%22and%22%2C%22awareness%22%2C%22act%22%5D%7D&s=1&r=2.*
[21] *https://www.deltadentalinstitute.com/news/press-releases/launches-campaign-to-drive-greater-diversity-in-the-oral-health-workforce/.*
[22] *https://www.deltadentalinstitute.com/fund/.*
[23] *https://hsdm.harvard.edu/news/study-finds-expanded-dental-workforce-could-lead-better-health-outcomes-children.*

through research, giving initiatives, and other activities in the communities we serve. In 2021,[24] Delta Dental made key investments totaling $106 million, nearly a quarter of which were dedicated to oral health education and workforce development. As part of this giving, Delta Dental has made efforts to expand access to care by supporting dental treatment and prevention programs, such as free dental clinics; advancing health equity through scholarships and grants for underrepresented students pursuing careers in oral health; and funding research and supporting new care models and technologies, like medical-dental integration and teledentistry, to help develop new solutions to improve care.

Subcommittee Actions to Reduce Oral Health Disparities

Based on the state of oral health in America,[25] there is a clear link between oral health and overall health and a need to address barriers that vulnerable patients face in accessing high-quality oral health care. We commend the Subcommittee's hearing on this topic, as it brought these very matters to light. Our Driving Greater Diversity in the Oral Health Workforce campaign was created in hopes of diversifying the oral health workforce and subsequently improving oral health outcomes for racially and ethnically diverse patients and communities. We believe the country would benefit from programs like our campaign, and the Subcommittee's recognition of disparities in oral health care and the lack of diversity in the oral health workforce would make way for these very programs to develop and grow.

Our aim is to create an oral health workforce that is racially and ethnically diverse, culturally competent, and reflects the changing demographics of the U.S. population. To accomplish this, we recommend that members of the Subcommittee create legislation that authorizes a federal program to create a more diverse and culturally competent dental workforce, following the framing of what Delta Dental is trying to accomplish through our ongoing campaign.

Conclusion

Chairman Cardin and Ranking Member Daines, thank you again for holding a hearing on this critically important topic. I hope we are able to continue this conversation in the coming months, as significant work remains to address oral health disparities. We were pleased to see Dr. Cherae M. Farmer-Dixon, Dean of Meharry Medical College's School of Dentistry, one of only two historically black colleges and universities (HBCU) dental schools in the U.S., on the panel. There are additional experts with diverse backgrounds and robust experience addressing oral health disparities in their communities from whom the committee can continue to learn.

As the nation's oral health leader, serving more than 85 million Americans and offering the largest network of dentists in all 50 states, Washington, D.C., and Puerto Rico, Delta Dental is eager to lend its expertise in oral health to inform future legislative initiatives. As issues in this important policy area arise, we welcome the opportunity to work with you to move those policies forward. Please consider the Delta Dental Institute as a key resource and do not hesitate to contact us should you have any questions.

FAMILIES USA
1225 New York Avenue, NW, Suite 800
Washington, DC 2005
main 202–628–3030
fax 202–347–2417
FamiliesUSA.org

Chairman Cardin and Ranking Member Daines, Families USA would like to thank you and the entire Finance Subcommittee on Health Care for this important and timely hearing, and to offer our sincere appreciation to all of today's witnesses for lifting up the critical need to improve our oral health care system. Oral health care is key to overall health and wellness, employment opportunities, economic stability, and social connectedness. Families USA supports addressing the disparities in access to oral health care and finding solutions to ensure all families have access to affordable and quality oral health, including through comprehensive oral health coverage in Medicare and Medicaid.

---

[24] *https://2021cir.deltadental.com/.*

[25] *https://www.deltadental.com/content/dam/ddpa/us/en/press-releases/DDPA_State%20of%20Oral%20Health%20Report_2022-Release.pdf.*

Oral Health Care is Health Care

The Centers for Disease Control[1] and the World Health Organization[2] have both declared that oral health is a key indicator of overall health, well-being, and quality of life. Additionally, longstanding evidence shows that poor oral health harms our physical, mental, and economic well-being.

When people cannot access the care they need, oral health problems can prevent them from eating, working, securing employment, and staying healthy. A recent survey of middle-aged adults revealed that nearly four in ten had dental problems within the past two years that caused pain, difficulty eating, and work absences.[3]

When oral disease goes untreated, people are at a higher risk for diabetes, heart disease, stroke, COVID–19, and even death.[4] If people already have these health conditions, poor oral health can make them worse. This can be a particularly acute problem for our nation's older adults, over two thirds of whom have untreated gum disease and roughly a fifth of whom have untreated tooth decay.[5]

Additionally, lack of access to oral health care during pregnancy can lead to poor health outcomes for both the mother and baby.[6] Poor oral health raises the risk of high blood pressure during, which can lead to major complications and even maternal deaths.[7] It also increases the risk of poor birth outcomes, such as low birth weight or premature birth.[8] Moreover, children are three times more likely to have dental disease if their mother was not able to receive dental care during pregnancy.[9]

Oral Health Remains Out of Reach

Oral health care is central to overall health, yet for far too many people, access to affordable and high-quality dental care is out of reach. Americans are roughly four times more likely to lack dental insurance than medical insurance, with the greatest rates of uninsurance among racial and ethnic minorities.[10] Without insurance, oral health care is too expensive for many people to afford. For example, the average cost of a root canal can cost between $750 and $1,200.[11] Due to this, dental care remains the number one medical service families skip due to cost.[12] According to CareQuest

---

[1] *https://www.cdc.gov/oralhealth/basics/index.html.*

[2] *https://www.who.int/health-topics/oral-health#tab=tab_1.*

[3] University of Michigan Institute for Healthcare Policy and Innovation, "Dental Care at Midlife: Unmet Needs, Uncertain Future," *https://www.healthyagingpoll.org/reports-more/report/dental-care-midlife-unmet-needs-uncertain-future.*

[4] Victoria Sampson, Nawar Kamona, and Ariane Sampson, "Could There Be a Link between Oral Hygiene and the Severity of SARSCoV–2 Infections?", Nature (June 26, 2020), *https://www.nature.com/articles/s41415-020-1747-8;* Michael L. Barnett, "The Oral-Systemic Disease Connection," *The Journal of the American Dental Association* 137 (2006), *https://doi.org/10.14219/jada.archive.2006.0401.*

[5] Centers for Disease Control, Older Adult Oral Health, *https://www.cdc.gov/oralhealth/basics/adult-oral-health/adult_older.htm#:~:text=About%202%20in%203%20(68,or%20older%20have%20gum%20disease.&text=Tooth%20loss.,65%2D74%20(13%25).*

[6] Centers for Disease Control, Pregnancy and Oral Health, *https://www.cdc.gov/oralhealth/publications/features/pregnancy-and-oral-health.html#:~:text=Pregnancy%20may%20make%20women%20more,for%20the%20mother%20and%20baby.*

[7] Mark Ide and Panos N. Papapanou, "Epidemiology of Association between Maternal Periodontal Disease and Adverse Pregnancy Outcomes—Systematic Review," *Journal of Clinical Periodontology* 40, Suppl. 14 (2013): S181–S194, *https://onlinelibrary.wiley.com/doi/pdf/10.1111/jcpe.12063.*

[8] Dorota T. Kopycka-Kedzierawski et al., "Association of Periodontal Disease with Depression and Adverse Birth Outcomes: Results from the Perinatal Database; Finger Lakes Region, New York State," PLOS ONE 14, no. 4 (April 18, 2019): e0215440, *https://doi.org/10.1371/journal.pone.0215440.*

[9] Bruce Dye, Clemencia Vargas, Jessica Lee, Laurence Madger, and Norman Tinanoff, "Assessing the Relationship Between Children's Oral Health Status and That of Their Mothers," *The Journal of the American Dental Association,* February 2011, *https://jada.ada.org/article/S0002-8177(14)61498-7/fulltext.*

[10] Melissa Burroughs, Danny A. Kalash, Colin Reusch, Ifetayo B. Johnson, and Kata M. Kertesz, "An Oral Health Equity Agenda for the Biden Administration," February 24, 2021, *https://familiesusa.org/resources/an-oral-health-equity-agenda-for-the-biden-administration/.*

[11] Colgate, "What Root Canals Cost and Why the Cost Varies," January 9, 2023, *https://www.colgate.com/en-us/oral-health/root-canals/what-root-canals-cost-why-cost-varies.*

[12] Eliot Fishman, "Why Strong Health Care Policies in Reconciliation Are Necessary to Advancing Racial Equity," Families USA, October 2021, *https://familiesusa.org/wp-content/uploads/2021/10/COV-2021-349_Why-Strong-Health-Care-Policies-in-Reconciliation-Are-Necessary-to-Advancing-Racial-Equity.pdf.*

Institute research, 93% of individuals living in poverty have unmet dental needs, compared with 58% in high-income families.[13]

These problems are even greater for communities of color, rural communities, and the disability community. Black and non-white Hispanic adults are more likely to face cost barriers to dental care than White adults, and this gap has been increasing over time.[14] Among Black older adults, the percent of individuals who have lost of all their natural teeth is 31%—almost double the national average—with minimal change over the past decade.[15] Prior to the COVID–19 pandemic, seven out of ten Black individuals and six out of ten Hispanic individuals accessing health coverage through Medicare reported they did not see a dentist in the last year compared to four out of ten of their white counterparts—and we know the pandemic exacerbated these disparities.[16]

Residents in rural America face major difficulties in access, coverage, and geography that limit their ability to obtain good oral health care. An analysis of 2016 Behavioral Risk Factor Surveillance System data found that 20% of rural older adults have not seen a dentist or visited a dental clinic for more than 5 years, compared to 14% of non-rural older adults.[17] In rural areas, unmet oral health needs can exacerbate other health problems that are common in these communities—studies show strong links between oral health and diabetes, a disease with much higher mortality rates in rural areas than in more urban locations.[18]

Many adults with disabilities experience extraordinary barriers to good oral health. About 8 million disabled adults under age 65 rely on Medicare for coverage, and 4 million of these adults are dually eligible for Medicaid. However, both Medicare and Medicaid leave significant gaps in comprehensive oral health coverage. The lack of proper access to oral health care has significant impacts for individuals with disabilities because they commonly have multiple chronic health conditions.[19] Additionally, few dental offices provide accommodations to serve adults with physical or other disabilities. The need for accommodations varies among people with congenital, acquired, physical and intellectual disabilities and adds additional difficulties accessing quality oral health care.[20]

Ensuring Coverage in Medicare and Medicaid

While there are a variety of solutions to address the oral health care crisis, Families USA believes that adding a mandatory, comprehensive oral health benefit in Medicare and Medicaid would be the most impactful way to provide critical relief for millions of families.

Currently, two-thirds of older adults and people with disabilities who rely on the Medicare program for their insurance, often living on fixed incomes, do not have any source of oral health coverage. Adding an oral health benefit to Medicare would

---

[13] Carequest Institute of Oral Health, "Health Equity," *https://www.carequest.org/topics/health-equity.*

[14] Marko Vujicic, Ph.D., Chelsea Fosse, D.M.D., M.P.H., Colin Reusch, M.P.A., and Melissa Burroughs, "Making the Case for Dental Coverage for Adults in All State Medicaid Programs," July 2021, *https://familiesusa.org/wp-content/uploads/2021/07/HPI-CC-FUSA-WhitePaper_0721.pdf.*

[15] Centers for Disease Control and Prevention, "Oral Health Surveillance Report 2019, Trends in Dental Caries and Sealants, Tooth Retention, and Edentulism, United States, 1999–2004 to 2011 to 2016" (2019), available at *https://www.cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf.*

[16] Eliot Fishman, "Why Strong Health Care Policies in Reconciliation Are Necessary to Advancing Racial Equity," Families USA, October 2021, *https://familiesusa.org/wp-content/uploads/2021/10/COV-2021-349_Why-Strong-Health-Care-Policies-in-Reconciliation-Are-Necessary-to-Advancing-Racial-Equity.pdf.*

[17] Cheryl Fish-Parcham and Melissa Burroughs, "For Rural Seniors, Improving Overall Health Requires Improving Oral Health Care," Families USA, December 18, 2018, *https://familiesusa.org/resources/for-rural-seniors-improving-overall-health-requires-improving-oral-health-care/.*

[18] Cheryl Fish-Parcham, Melissa Burroughs, Eric P. Tranby, and Avery R. Brow, "Addressing Rural Seniors' Unmet Needs for Oral Health Care," *Health Affairs,* May 6, 2019, *https://familiesusa.org/resources/addressing-rural-seniors-unmet-needs-for-oral-health-care/.*

[19] Cheryl Fish Parcham, "Improving Access to Oral Health Care for Adults with Disabilities Can Improve Their Health and Well-Being," Families USA, September 2019, *https://familiesusa.org/wp-content/uploads/2019/10/OH_Oral-Health-and-People-with-Disabilities_IssueBrief.pdf.*

[20] Cheryl Fish Parcham, "Improving Access to Oral Health Care for Adults with Disabilities Can Improve Their Health and Well-Being," Families USA, September 2019, *https://familiesusa.org/wp-content/uploads/2019/10/OH_Oral-Health-and-People-with-Disabilities_IssueBrief.pdf.*

allow 60 million older adults and people with disabilities to access dental care.[21] There is very strong support for adding such a benefit; in 2021, roughly nine in ten voters supported Medicare oral health coverage.[22]

Ensuring comprehensive coverage in Medicaid would be another way to safeguard oral health access for millions of families. Currently, states have a patchwork of oral health coverage in Medicaid including many that have no coverage or only provide it in emergency situations.[23] Adding a comprehensive benefit in Medicaid would not only provide needed whole-person care for millions of people, but it could also save our health system $2 billion annually. With better access to oral health care, fewer people would be reliant on emergency departments to alleviate dental pain. And the data show that states that offer more comprehensive care spend less per person on dental care than those that don't provide any benefits or only offer emergency coverage.[24]

The current lack of coverage for oral health services in Medicare and Medicaid is a fundamental gap, and without action it will be extremely difficult to make progress on other important components of improving oral health. Coverage is a critical step toward making progress on integrating dental and medical care, ensuring oral health providers are affordable and available in underserved areas, improving access to telehealth, and many of the other important issues raised in today's hearing.

Conclusion

Millions of individuals and families lack access to affordable, quality oral health coverage. Congress has both the power and the responsibility to enact policy changes that acknowledge the reality that good oral health is central to overall health and financial stability. We appreciate the focus from Chair Cardin and Ranking Member Daines on this critical issue, and we look forward to continuing to work closely with the Finance Subcommittee on Health Care to bring to light the deep disparities in oral health care, and the solutions to ensure that our health doesn't depend on our wealth.

HALEON
184 Liberty Corner Road
Warren, NJ 07059

Statement of Elizabeth Brewer, MS, MPH, Head of U.S. Government Affairs

Chairman Cardin, Ranking Member Daines, and members of the Subcommittee, on behalf of Haleon and the millions of consumers who use our oral health products we thank you for convening this hearing to put a spotlight on the unequal access to oral health care that some racial/ethnic and socioeconomic groups experience. We urge your subcommittee to take action on this important issue that impacts people's overall health, ability to work and ability to attend school.

Haleon is a world-leading consumer health company with a clear purpose to deliver better everyday health with humanity. Haleon advocates for improving oral health and hygiene as an integral part of health care. Poor oral health and hygiene can cause tooth decay, gum disease and tooth loss among a variety of other health complications. Populations with a greater oral health risk include individuals with chronic diseases and weakened immune systems. Insufficient or inadequate dental care can worsen chronic health problems like diabetes and cardiovascular disease,

---

[21] Melissa Burroughs, Eliot Fishman, Garrett Hall, Jen Taylor, "What's at Stake for America's Families: Why Congress Must Go Big and Bold in Reconciliation to Improve Health and Health Care for Millions of People," Families USA, September 2021, *https://familiesusa.org/wp-content/uploads/2021/09/COV-2021-262_Whats-at-Stake-Report.pdf.*

[22] Families USA, "Medicare Oral Health Coalition: Polls Repeatedly Show Overwhelming Support for Medicare Dental," October 21, 2021, *https://familiesusa.org/resources/medicare-oral-health-coalition-polls-repeatedly-show-overwhelming-support-for-medicare-dental/*.

[23] Marko Vujicic, Ph.D., Chelsea Fosse, D.M.D., M.P.H., Colin Reusch, M.P.A., and Melissa Burroughs, "Making the Case for Dental Coverage for Adults in All State Medicaid Programs," July 2021, *https://familiesusa.org/wp-content/uploads/2021/07/HPI-CC-FUSA-WhitePaper_07 21.pdf.*

[24] Melissa Burroughs and Colin Reusch, "New Data: Medicaid Adult Dental Coverage is Wise Investment for Economic Recovery, Health," Families USA Insights Blog, July 8, 2021, *https://familiesusa.org/resources/new-data-medicaid-adult-dental-coverage-is-wise-investment-for-economic-recovery-health/*.

hinder timely diagnosis of severe medical conditions, and lead to avoidable complications that may require costly emergency room visits.[1]

While access to oral health has improved for many Americans there continues to be disparities in access. In the United States, people are more likely to have poor oral health if they are low-income, uninsured, and/or members of racial/ethnic minority, immigrant, or rural populations who have suboptimal access to quality oral health care. These inequities extend throughout the life course and include differences in access to affordable healthy foods, professional dental prevention and treatment services, and dental insurance.[2] These same groups are less likely to afford to pay out-of-pocket for dental care, do not have private or public dental insurance, or can't get time off from work to get to dental care. Dental expenses constitute more than a quarter of overall health care out-of-pocket (OOP) expenditures and are reported to present higher financial barriers than medical, prescription pharmaceuticals, and mental health care.[3]

As you know, the Medicare program covers a majority of all Americans age 65 and older and plays a vital role in the quality and longevity of their lives. However, the program has also long fallen short in providing those beneficiaries with sufficient coverage for essential oral and dental treatment. Two-thirds of Medicare beneficiaries lack oral health coverage, and 49% of Medicare beneficiaries have not seen a dentist in the last 12 months (as of 2017).[4] A recent study found that use of dental services fell at age 65 for both enrollees in tradition fee-for-service and Medicare Advantage.[5] As a result, medical problems and treatment that can be proactively addressed with such care have instead gone unchecked, delayed, or canceled, resulting in serious clinical, human, and fiscal implications.

The committee's important hearing is being held at an equally important time. As you know, the Traditional Medicare program covers a majority of all Americans age 65 and older and plays a vital role in the quality and longevity of their lives. However, the program has also long fallen short in providing those beneficiaries with sufficient coverage for essential oral and dental treatment. As a result, medical problems and treatment that can be proactively addressed with such care have instead gone unchecked, delayed, or canceled, resulting in serious clinical, human, and fiscal implications.

Oral health is well established as being essential to a person's overall health and well-being. On the basis of their clinical experience and extensive peer-reviewed research, numerous medical, nursing, and specialty organizations view whole-body systemic health as a priority for the future of American health care. Additionally, they have identified specific diseases, conditions, and clinical procedures for which resolution of oral and dental infections is fundamentally necessary to the delivery and efficacy of medical procedures covered by the Medicare program.

Despite this documented linkage, access to needed oral and dental care has long suffered from inequities that limit many older adults' access to oral and dental care. As a consequence, millions of Medicare beneficiaries, particularly in marginalized and medically underserved communities, face daunting obstacles to the proactive and effective clinical care they need and deserve.

This coverage gap exposes Americans age 65 and older to tremendous risk. Absent access to oral and dental care, many Medicare beneficiaries are unable to receive covered medical treatment they need due to the clinical risks posed by their untreated oral and dental conditions. This places their health at risk and results in worsening medical conditions, avoidable institutionalization, and, tragically, higher mortality rates. Similarly, their quality of life is deeply compromised by the lack of oral treatment, limiting many beneficiaries' ability to be free of pain and enjoy productive and fulfilling lives.

---

[1] Oral Health in America: A Report of the Surgeon General. U.S. Department of Health and Human Services, *https://onlinelibrary.wiley.com/doi/epdf/10.1111/jcpe.12060.*

[2] *Id.*

[3] Vujicic M, Buchmueller T, Klein R. Dental care presents the highest level of financial barriers, compared to other types of health care services. *Health Affairs.* 2016a;35(12):2176–82, *https://doi.org/10.1377/hlthaff.2016.0800.*

[4] Kramarow EA. Dental care among adults aged 65 and over, 2017. NCHS Data Brief, No 337. Hyattsville, MD: National Center for Health Statistics. 2019. Accessed at: *https://www.cdc.gov/nchs/products/databriefs/db337.htm.*

[5] Simon, L. Song Z., and Barnett, M. Dental Services Use: Medicare Beneficiaries Experience Immediate and Long-Term Reductions After Enrollment, *Health Affairs,* Vol. 42, No. 2, February 2023, *https://doi.org/10.1377/hlthaff.2021.01899.*

At the same time, restricted access to oral and dental treatment compels beneficiaries, taxpayers, and the Medicare program to bear higher costs than would otherwise be necessary. By way of example, Avalere Health analyzed the savings leading commercial health insurers are realizing by providing dental coverage to their enrollees. Even the discrete instance examined by Avalere Health (coverage of periodontitis treatment for beneficiaries with specific chronic conditions) revealed its potential to achieve net Medicare savings of $63.5 billion due to the avoidance of costly medical complications.

Fortunately, progress is being made to close the Medicare program's coverage gap. Specifically, the Physician Fee Schedule final rule for 2023 clarified medical coverage for dental services that are inextricably linked and substantially related and integral to organ transplant surgery, cardiac valve replacement, valvuloplasty procedures, and head and neck cancers. The final rule also created the opportunity for further coverage expansion by establishing "a process to identify for [the Medicare program's] consideration and review submissions of additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services." Finally, the rule confirmed Medicare coverage for the wiring of teeth related to covered medical services, the reduction of jaw fractures, the extraction of teeth in preparation for radiation treatment of neoplastic disease, dental splints for covered treatment of certain medical conditions, and oral or dental examinations relating to renal transplant surgery.

By clarifying Medicare coverage of medically necessary dental services and opening an important opportunity for stakeholders to suggest clinical scenarios to which medically necessary oral and dental services should be extended in the future, the Medicare program has opened the door to meaningful progress to improve the clinical success of covered medical services. That said, the promise of equitable access to clinically- and cost-effective oral and dental care depends to a significant degree on this committee and body.

Oral health thought leaders have submitted evidence-based nominations for consideration by the Centers for Medicare and Medicaid Services (CMS). If accepted as part of the annual process for continued expansion of medically necessary coverage, the nominated conditions will be included in the Physician Fee Schedule proposed rule for 2024. If subsequently advanced to the Fee Schedule's final rule, the coverage gap long faced by millions of Medicare beneficiaries will take another important step towards closure.

Specifically, the nominated conditions are as follows:

- Medical coverage of medically necessary coverage of diabetes, consistent with extensive evidence that medical management of diabetes mellitus by reducing blood sugar levels is substantially improved by non-surgical periodontal and preventive dental services, as well as the Final Rule's solicitation of clinical scenarios including "management of chronic conditions such as diabetes."
- Medical coverage of medically necessary coverage of blood and solid tumor cancers, due to the close association between cancer, cancer treatment, immunosuppression, and the heightened risk of oral health-related complications during chemotherapy and radiation adjuvant therapies.
- Medical coverage of medically necessary coverage of complications related to systemic autoimmune disease, consistent with extensive evidence that impacted persons are at much higher risk of advanced dental decay, tooth loss, and gum disease, as well as extensive evidence linking periodontitis to the development of rheumatoid arthritis and other autoimmune diseases.

Inclusion of the above medical coverage would have a direct and meaningful impact in the lives of many Medicare beneficiaries. As a result, we urge this committee to utilize its oversight of CMS and engage with Agency officials as they consider these nominations and formulate this year's Physician Fee Schedule proposed rule. With your continued leadership, we are confident further progress will be realized in building a more equitable, clinically successful, and cost-effective Medicare program for all beneficiaries.

Haleon welcomes the opportunity to serve as a resource to you and your staff. Please do not hesitate to let me know if we can address any questions you may have or provide additional information. We thank you for the opportunity to submit written testimony for the record.

STATEMENT OF JUDITH A. JONES, D.D.S., M.P.H., D.SC.D., PROFESSOR, UNIVERSITY OF DETROIT MERCY SCHOOL OF DENTISTRY

Chairman Cardin, Ranking Member Daines, and members of the subcommittee, thank you for convening a hearing on "An Oral Health Crisis: Identifying and Addressing Health Disparities" and for this opportunity to submit written testimony.

Having reviewed the transcript of the oral testimony, I concur with all the speakers, and in particular Drs. Cherae Farmer Dixon, Marko Vujicic and Senator Elizabeth Warren. As a Geriatric Dentist and specialist in Dental Public Health, I have spent my career caring and advocating for oral health care for older adults, veterans, persons with cognitive decline, and the homeless.

Despite the documented linkage between oral and general health, millions of Medicare beneficiaries, particularly in marginalized and medically underserved communities, face daunting obstacles to the proactive and effective clinical care they need and deserve. For this reason, I have long advocated for the inclusion of dental care in Medicare Part B. However, in the absence of successful legislation in support of such inclusion, I write in full support of medically necessary dental care for Medicare beneficiaries as a stop-gap measure.

The Physician Fee Schedule final rule for 2023 clarified medical coverage for dental services that are inextricably linked and substantially related and integral to organ transplant surgery, cardiac valve replacement, valvuloplasty procedures, and head and neck cancers (in FY24). The final rule also created the opportunity for further coverage expansion by establishing "a process to identify for [the Medicare program's] consideration and review submissions of additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services." Finally, the rule confirmed Medicare coverage for the wiring of teeth related to covered medical services, the reduction of jaw fractures, the extraction of teeth in preparation for radiation treatment of neoplastic disease, dental splints for covered treatment of certain medical conditions, and oral or dental examinations relating to renal transplant surgery.

By clarifying Medicare coverage of medically necessary dental services and opening an important opportunity for stakeholders to suggest clinical scenarios to which medically necessary oral and dental services should be extended in the future, the Medicare program has opened the door to meaningful progress to improve the clinical success of covered medical services. That said, the promise of equitable access to clinically- and cost-effective oral and dental care depends to a significant degree on this committee and body.

Oral health thought leaders have submitted evidence-based nominations for consideration by the Centers for Medicare and Medicaid Services (CMS). If accepted as part of the annual process for continued expansion of medically necessary coverage, the nominated conditions will be included in the Physician Fee Schedule proposed rule for 2024. If subsequently advanced to the Fee Schedule's final rule, the coverage gap long faced by millions of Medicare beneficiaries will take another important step towards closure.

Specifically, the nominated conditions are as follows:

- Medical coverage of medically necessary coverage of diabetes, consistent with extensive evidence that medical management of diabetes mellitus by reducing blood sugar levels is substantially improved by non-surgical periodontal and preventive dental services, as well as the Final Rule's solicitation of clinical scenarios including "management of chronic conditions such as diabetes."
- Medical coverage of medically necessary coverage of blood and solid tumor cancers, due to the close association between cancer, cancer treatment, immunosuppression, and the heightened risk of oral health-related complications during chemotherapy and radiation adjuvant therapies.
- Medical coverage of medically necessary coverage of complications related to systemic autoimmune disease, consistent with extensive evidence that impacted persons are at much higher risk of advanced dental decay, tooth loss, and gum disease, as well as extensive evidence linking periodontitis to the development of rheumatoid arthritis and other autoimmune diseases.

Inclusion of the above medical coverage would have a direct and meaningful impact in the lives of many Medicare beneficiaries. I urge this committee to use its oversight of CMS and engage with Agency officials as they consider these nominations and formulate this year's Physician Fee Schedule proposed rule. With your contin-

ued leadership, I am confident further progress will be realized in building a more equitable, clinically successful, and cost-effective Medicare program for all beneficiaries.

I would welcome the opportunity to serve as a resource to you and your staff. Please do not hesitate to let me know if I can address any questions you may have or provide additional information.

Thank you.

JUSTICE IN AGING

April 12, 2023

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

RE: March 29, 2023 Subcommittee Hearing on "An Oral Health Crisis: Identifying and Addressing Health Disparities"

This statement is submitted on behalf of Justice in Aging, an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We focus our efforts primarily on advocating for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

We appreciate you holding this historic hearing on the oral health crisis and disparities in access to necessary oral health care. Justice in Aging has worked extensively to improve the oral health of low-income older adults particularly for communities of color *(https://www.justiceinaging.org/wp-content/uploads/2019/10/Addressing-Oral-Health-Equity-by-Adding-a-Dental-Benefit-to-Medicare.pdf)* and older individuals with disabilities *(https://justiceinaging.org/wp-content/uploads/2020/10/Adding-a-Dental-Benefit-to-Medicare-Disability.pdf)* who experience high rates of oral health disease impacting their overall health and quality of life. We urge Congress to address these inequities by (1) expanding Medicare coverage to include a comprehensive oral health benefit in Medicare Part B; (2) extending guaranteed, comprehensive dental coverage to all Medicaid enrollees; and (3) expanding eligibility for dental care for veterans provided by the Department of Veterans Affairs.

Lack of Oral Health Coverage Drives Disparities in Access and Health for Older Adults

The lack of affordable oral health coverage for older adults is a significant barrier to accessing oral health care and exacerbates racial, geographic, and disability-related health and wealth disparities. Yet, our nation's largest health programs serving older adults do not offer guaranteed coverage of oral health care. Medicare, the primary source of health coverage for older adults, explicitly excludes coverage *(https://www.justiceinaging.org/wp-content/uploads/2019/01/Creating-an-Oral-Health-Benefit-in-Medicare-A-Statutory-Analysis.pdf?eType=EmailBlastContent&eId=2071568b-2eb3-4b7b-a9ff-da101bff3bfa)* for most dental services, leaving 47% of Medicare enrollees—or 24 million—without any oral health coverage.[1] Medicaid, which serves 7.5 million people age 65 and over[2] and many more older adults ages 50 to 64, does not require states to cover adult dental benefits resulting in inequi-

[1] Kaiser Family Foundation, "Medicare and Dental Coverage: A Closer Look," July 28, 2021, available at *https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/*.

[2] Kaiser Family Foundation, "Medicaid Financial Eligibility in Pathways Based on Old Age or Disability in 2022: Findings from a 50-State Survey," June 11, 2022, available at *https://www.kff.org/report-section/medicaid-financial-eligibility-in-pathways-based-on-old-age-or-disability-in-2022-findings-from-a-50-state-survey-issue-brief/*.

table coverage across the country.[3] Meanwhile, only 15% of the 9.2 million U.S. veterans receive comprehensive dental coverage through the office of Veterans Affairs.[4]

Oral health care is expensive, so it is not surprising that those without coverage or even those with limited coverage cite not being able to pay for treatment as the biggest barrier to accessing care.[5] As of 2020, the median income for older adults is just $26,668.[6] Moreover, 9% of older adults—or 5 million individuals—were living in poverty. Black (17%), Hispanic (17%), and Asian (12%) older adults experience poverty at much higher rates compared to white older adults (7%).[7]

Unable to afford care, many older adults must forgo treatment. For example, surveys show that **nearly half of all Medicare enrollees—approximately 30 million older adults and people with disabilities—did not have a dental visit in the last year.**[8] This is even more severe among populations of color who have lower incomes compared to white older adults due to ongoing and historic racial discrimination. **Sixty-eight percent of Black and 61% of Hispanic Medicare enrollees, for example, did not see a dentist in the last year compared to 42% of white Medicare enrollees.**[9]

Without access to treatment, older adults experience high rates of poor oral health, with certain populations suffering more acutely. Nationwide, 17% of older adults have no remaining natural teeth—a rate that has been steadily decreasing each year. Yet, **among Black older adults, the percent of individuals with complete tooth loss is 28%—almost double the national average—with minimal change over the past decade.**[10] Black and Hispanic older adults are also two to three times more likely to have severe periodontitis—or gum disease—than white older adults and twice as likely to have untreated tooth decay.[11]

The impact of poor oral health on overall health for older adults is substantial and exacerbates health disparities while driving increased health care spending for chronic conditions. For example, periodontitis is associated with chronic diseases like diabetes and heart disease, conditions that disproportionately impact communities of color.[12] Most recently, **oral health has been linked to Alzheimer's and dementia, conditions that Black and Hispanic older adults are twice as likely as white older adults to experience.**[13] Research shows that individuals with dementia are more likely to have poor oral health and poor oral health increases the risk of developing dementia.[14] Further, untreated gum disease can lead to infections like aspiration pneumonia resulting in costly hospitalizations and deaths,[15] particularly among nursing facility residents, while ongoing pain associ-

---

[3] National Academy for State Health Policy, "State Medicaid Coverage of Dental Services for General Adult and Pregnant Populations," October 20, 2022, available at *https://nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/*.

[4] CareQuest Institute for Oral Health and American Institute of Dental Public Health, "Veteran Oral Health: Expanding Access and Equity," 2021, available at *https://www.carequest.org/system/files/CareQuest_Institute_Veteran-Oral-Health.pdf*.

[5] Vujicic, M. et al., "Dental Care Presents the Highest Level of Financial Barriers, Compared to Other Types of Health Care Services," *Health Affairs,* December 2016, available at *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0800*.

[6] Administration for Community Living, "2021 Profile of Older Americans," November 2022, available at *https://acl.gov/sites/default/files/Profile%20of%20OA/2021%20Profile%20of%20OA/2021ProfileOlderAmericans_508.pdf*.

[7] *Id.*

[8] Kaiser Family Foundation, "Medicare and Dental Coverage: A Closer Look," July 28, 2021, available at *https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/*.

[9] *Id.*

[10] National Institutes of Health, "Oral Health in America: Advances and Challenges," 2021, Section 3B Oral Health Across the Lifespan: Older Adults, available at *https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf#page=411*.

[11] *Id.*

[12] *Id.*

[13] Alzheimer's Association, "2023 Alzheimer's Disease Facts and Figures," 2023, available at *https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf*.

[14] Oral Health in America, *infra* endnote x.

[15] Pusins, J., "Oral Health and Aspiration Pneumonia," Today's Geriatric Medicine, 2018, available at *https://www.todaysgeriatricmedicine.com/archive/ND18p16.shtml. See also,* Muller, F., "Oral Hygiene Reduces the Mortality from Aspiration Pneumonia in Frail Elders," 2015, available at *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4541086/*.

ated with untreated oral health disease increases the likelihood that opioids will be prescribed and abused.[16]

Older Adults Need Comprehensive Dental Coverage to Remedy Inequities

Dental coverage is the largest determinant of whether an individual can access oral health care. Therefore, expanding coverage is an essential step in ensuring access and addressing disparities. In fact, research demonstrates that expanding dental coverage reduces racial and ethnic disparities in access to dental services.[17] Adding a dental benefit to Medicare Part B would provide comprehensive coverage to all 61 million older adults and people with disabilities enrolled in the program and reduce disparities based on race, disability, income, and geography. As the National Institutes of Health reported, "because the removal of cost and insurance barriers promotes the use of dental services by older adults, the addition of an oral health benefit in Medicare would improve access to care nationwide, especially for low-income older adults and those of some racial/ethnic groups."[18] Meanwhile, extending guaranteed comprehensive dental coverage to all adult Medicaid enrollees and expanding Veteran's coverage would ensure older adults and aging adults with disabilities not enrolled in Medicare have access to necessary dental treatment.

Accordingly, we urge Congress to (1) add a comprehensive oral health benefit in Medicare Part B; (2) extend guaranteed, comprehensive dental coverage to adult Medicaid enrollees; and (3) expand eligibility for dental care for veterans provided by the Department of Veterans Affairs.

Thank you again for holding this hearing and for the opportunity to provide input. Should any questions arise, you can reach me at achrist@justiceinaging.org.

Sincerely,

Amber Christ
Managing Director of Health Advocacy

LETTER SUBMITTED BY DUSHANKA V. KLEINMAN, D.D.S., M.SC.D.

U.S. Senate
Committee on Finance
Subcommittee on Health Care

Chairman Cardin, Ranking Member Daines, and esteemed members of the subcommittee, thank you for convening a hearing on "An Oral Health Crisis: Identifying and Addressing Health Disparities" and for this opportunity to submit this testimony.

By way of background, I am a recently retired Professor, Principal Associate Dean, and Associate Dean for Research at the University of Maryland School of Public Health, a Diplomat of the American Board of Dental Public Health, and a member of the Santa Fe Group. Prior to joining the University of Maryland in 2007, I had the privilege of providing public service for 28 years as the Deputy Director and Acting Director of the National Institute of Health's National Institute of Dental and Craniofacial Research (NIDCR) and in the U.S. Public Health Service Commissioned Corps, where I served as Rear Admiral, Assistant Surgeon General, and Chief Dental Officer. In these roles, I have witnessed the critical importance of integrating oral health literacy together with the application of new knowledge and health services. This was clearly demonstrated by the rapid actions taken after the tragic passing of Deamonte Driver. Having devoted my entire dental public health professional career services in the state of Maryland, I have long been deeply appreciative of your commitment to and leadership in advancing holistic health care including oral and dental care and health literacy.

The committee's important hearing is being held at a very important time. As you know, the Traditional Medicare program covers a majority of all Americans age 65 and older and plays a vital role in the quality and longevity of their lives. However, the program has also long fallen short in providing those beneficiaries with suffi-

---

[16] Nack, B., et al., "Opioid Use Disorder in Dental Patients: The Latest on How to Identify, Treat, Refer and Apply Laws and Regulations in Your Practice" (2017), available at *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5579823/*

[17] Wheby, G., et al., "Racial and Ethnic Disparities in Dental Services Use Declined After Medicaid Adult Dental Coverage Expansions," *Health Affairs,* January 2022, available at *https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01191.*

[18] Oral Health in America, *infra* endnote x.

cient coverage for essential oral and dental treatment. As a result, medical problems and treatment that can be proactively addressed with such care have instead gone unchecked, been delayed or canceled, with serious clinical, human, and fiscal implications.

Oral health is well established as being essential to a person's overall health and well-being. On the basis of their clinical experience and extensive peer-reviewed research, numerous medical, nursing, and specialty organizations view whole-body systemic health as a priority for the future of American health care. Additionally, they have identified specific diseases, conditions, and clinical procedures for which resolution of oral and dental infections is fundamentally necessary to the delivery and efficacy of effective medical procedures covered by the Medicare program.

Despite this documented linkage, access to needed oral and dental care has long suffered from inequities that limit access to oral and dental care for many older adults. As a consequence, millions of Medicare beneficiaries, particularly in marginalized and medically underserved communities, face daunting obstacles to the proactive and effective clinical care they need and deserve.

This coverage gap exposes Americans age 65 and older to tremendous risk. Absent access to oral and dental care, many Medicare beneficiaries are unable to receive covered medical treatment they need due to the clinical risks posed by their untreated oral and dental conditions. This places their health at risk and results in worsening medical conditions, avoidable institutionalization, and, tragically, higher mortality rates. Similarly, their quality of life is deeply compromised by the lack of oral treatment, limiting many beneficiaries' ability to be free of pain and enjoy productive and fulfilling lives.

At the same time, restricted access to oral and dental treatment compels beneficiaries, taxpayers, and the Medicare program to bear higher costs than would otherwise be necessary. By way of example, Avalere Health analyzed the savings leading commercial health insurers are realizing by providing dental coverage to their enrollees. Even the discrete instance examined by Avalere Health (coverage of periodontitis treatment for beneficiaries with specific chronic conditions) revealed its potential to achieve net Medicare savings of $63.5 billion over a ten-year period due to the avoidance of costly medical complications.

Fortunately, progress is being made to close the Medicare program's coverage gap. Specifically, the Physician Fee Schedule final rule for 2023 clarified medical coverage for dental services that are inextricably linked and substantially related and integral to organ transplant surgery, cardiac valve replacement, valvuloplasty procedures, and head and neck cancers. The final rule also created the opportunity for further coverage expansion by establishing "a process to identify for [the Medicare program's] consideration and review submissions of additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services." Finally, the rule confirmed Medicare coverage for the wiring of teeth related to covered medical services, the reduction of jaw fractures, the extraction of teeth in preparation for radiation treatment of neoplastic disease, dental splints for covered treatment of certain medical conditions, and oral or dental examinations relating to renal transplant surgery.

By clarifying Medicare coverage of medically necessary dental services and opening an important opportunity for stakeholders to suggest clinical scenarios to which medically necessary oral and dental services should be extended in the future, the Medicare program has opened the door to meaningful progress to improve the clinical success of covered medical services. *That said, the promise of equitable access to clinically- and cost-effective oral and dental care depends to a significant degree on this committee and body.*

Oral health thought leaders have submitted evidence-based nominations for consideration by the Centers for Medicare and Medicaid Services (CMS). If accepted as part of the annual process for continued expansion of medically necessary coverage, the nominated conditions will be included in the Physician Fee Schedule proposed rule for 2024. If subsequently advanced to the Fee Schedule's final rule, the coverage gap long faced by millions of Medicare beneficiaries will take another important step towards closure.

Specifically, the nominated conditions are as follows:

- Medical coverage of medically necessary coverage of diabetes, consistent with extensive evidence that medical management of diabetes mellitus by reducing blood sugar levels is substantially improved by non-surgical periodontal and

preventive dental services, as well as the Final Rule's solicitation of clinical scenarios including "management of chronic conditions such as diabetes."

- Medical coverage of medically necessary coverage of blood and solid tumor cancers, due to the close association between cancer, cancer treatment, immunosuppression, and the heightened risk of oral health-related complications during chemotherapy and radiation adjuvant therapies.
- Medical coverage of medically necessary coverage of complications related to systemic autoimmune disease, consistent with extensive evidence that impacted persons are at much higher risk of advanced dental decay, tooth loss, and gum disease, as well as extensive evidence linking periodontitis to the development of rheumatoid arthritis and other autoimmune diseases.

Inclusion of the above medical coverage would have a direct and meaningful impact in the lives of many Medicare beneficiaries. I can attest to this on a personal note: my own family benefitted from my husband's dental care prior to his aortic valve replacement procedure, which reduced the risk of infection that would have greatly compromised his treatment. As a result of all the factors described above, I would like to urge this committee to utilize its oversight of CMS and engage with Agency officials as they consider these nominations and formulate this year's Physician Fee Schedule proposed rule. With your continued leadership, I am confident further progress will be realized in building a more equitable, clinically successful, and cost-effective Medicare program for all beneficiaries.

I would welcome the opportunity to serve as a resource to you and your staff. Please do not hesitate to let me know if I can address any questions you may have or provide additional information.

Thank you.

Dushanka V. Kleinman D.D.S., M.Sc.D. (USPHS RADM (ret.)) Professor, Principal Associate Dean, and Associate Dean for Research (ret.), University of Maryland School of Public Health

---

LETTER SUBMITTED BY STEPHEN C. MITCHELL, DMD, MS
Director of Civitan-Sparks Clinics Dental Clinic
American Academy of Pediatric Dentistry Public Policy Advocate for Alabama

Executive Summary

Adults with severe intellectual and/or developmental disabilities (IDD) experience more severe dental disease while facing greater barriers to accessing dental care than any other population in America. This unique patient population often lacks the mental and/or physical capacity to care for their own mouth, are incapable of earning an income to pay for dental care on their own and are not guaranteed dental coverage with their medical Medicaid benefits. Therefore, this vulnerable population is left dependent on charitable care that is often incapable of providing the complex treatment they need. This paper intends to describe access to dental care problems facing America's special needs populations.

Key points:

- Dentistry is the most common unmet healthcare need for the severely disabled.
- Untreated dental decay and periodontal disease causes pain and infection in a population that lacks the ability to communicate their suffering.
- Each state must choose to offer dental coverage after age 21 for those whose severe disabilities qualify them for Medicaid medical coverage. Some states, like Alabama, choose not to.
- Severely affected patients often cannot safely receive dental care in a dental office and require treatment in a hospital operating room. However, Medicaid reimbursement for hospital facility fees and anesthesia services is below the cost of providing this care. A new CMS rules change could increase hospital reimbursement from $203 to $1,958. This should improve access to hospital based dental care, but each state will need to implement the rule.

Special Health Care Needs (SHCN) Defined and Scope of Need

The term "disability" has been used to describe individuals with a wide range of challenges that are beyond the scope of this discussion. **This paper will address adults with SHCN who were born with a moderate to severe cognitive and/or physical impairment like autism, cerebral palsy, and other syndromes.** This population fall into the category of "intellectual and developmental disabilities"

(IDD). The target population is comprised of individuals with impairments that qualify them for Medicaid medical benefits under Social Security.

According to Waldman, et al., in 2017, approximately 12.6% of Americans had a severe disability. The 2000 Surgeon General's report on Oral Health in American identified oral disease as a problem for those with SCHN and the 2021 follow-up report further documents the problem persists. Key barriers to oral health described are lack of third-party coverage, high costs associated with treating many oral conditions in the population, poor behavior during treatment, and too few dentists trained to provide care for this population.

Dental Needs and Challenges for This Population

Patients with severe IDD often lack the mental, behavioral, or physical ability to brush and floss themselves, cooperate for others to provide oral hygiene for them, or tolerate professional dental care in a traditional setting. This lack of daily preventive care increases incidences of both tooth decay and chronic inflammation and bone loss (periodontal disease) around the teeth. **Tooth decay leads to pain, infection and swelling that can trigger aggressive behavior in many of the intellectually impaired. Periodontal disease results in chronically ulcerated pockets of tissue around the teeth that destroys the supporting bone leading to tooth mobility, difficulty eating, and tooth loss. This chronic inflammation places a constant and significant physiological stress on the patient's body and serves as a portal for bacteria to enter the blood stream.** Difficulties eating also decrease nutritional intake and overall health.

Treatment for this population in a traditional dental office setting often requires the use of physical restraints to safely control the patient's behavior. Advanced pharmacologic sedation can help some cases but, due to the atypical anatomy and physiology of these patients, sedation carries significant risk of adverse reactions including death. Often, the safest method of providing dental care is to treat patients with severe IDD in a hospital operating room under general anesthesia. Simply stated, **providing advanced dental care for many adults with severe IDDs outside an operating room has and will continue to result in harm to these patients.** Unfortunately, it is often the only option available.

Insurance Coverage Gap

Medicaid provides *medical coverage* for many of the most severely affected individuals with IDD, regardless of socioeconomic status. However, **CMS only stipulates Medicaid dental coverage through age 21.** Some families carry their IDD loved one on their family dental policy until the child reaches 26y of age. After this age, only families that can afford a separate, stand-alone dental policy are able to carry dental insurance for their IDD loved ones. Most families simply pay out-of-pocket for the care they can afford.

Stand-alone dental policies rarely cover the hospitalization or general anesthesia required to safely treat this population, and private medical policies rarely cover dental treatment. Most of the IDD adult population falls into this gap where they lack either the medical coverage to gain access to medically necessary sedation/general anesthesia or the dental coverage to afford extractions and restorations.

Medicare plans have emerged that provided limited dental coverage for a small group of disabled citizens. Medicare Advantage (Part C) includes coverage called **Medicare Dual-Eligible Special Needs Plan (D–SNP).** Patients who qualify for these plans may receive dental coverage with a low annual spending limit. However, very few seem to qualify for these plans, as the plans require recipients be eligible for both Medicare and Medicaid, limiting eligibility to:

1. Medicaid eligible disabled who are over 65y of age.
2. Medicaid eligible disabled who have a Medicare eligible parent who is deceased or receiving Medicare benefits.
3. Patients who were able to work enough to become Social Security eligible prior to becoming disabled.

This coverage does not cover **patients who were born with profound intellectual and developmental disabilities, are between 21 and 65y of age, and whose parents are young enough to not qualify for Medicare.** These are often the most fragile and medically/behaviorally complex patients.

Access to Operating Room Dentistry: Nationally, the American Dental Association (ADA), American Academy of Pediatric Dentistry (AAPD) and American Association of Oral and Maxillofacial Surgeons (AAOMS) worked with the **US Centers**

for Medicare and Medicaid Services (CMS) on a rule change that improves hospital reimbursement for dental services. This rule creates a new code specific to dental care (APC 5871) that went into effect on January 1, 2023, and **increases facility fee reimbursement from $203.64 to $1,958.92.** However, if CMS does not mandate use of the new code, then state Medicaid agencies may choose to implement and reimburse for it. Also, note that while this rule change covers the medical costs of operating room dentistry, **it does not address the lack coverage for dental services.** It also does not address care delivered in ambulatory care centers instead of hospitals.

Conclusion:

The need for dental care for adults with profound intellectual and developmental disabilities is not being met by current healthcare system. **The current system relies on benevolence to meet the oral health needs of our most vulnerable Americans with intellectual and developmental disabilities, but this system is not capable of safely meeting the need.** America must act at the national level to address these oral health needs. Extending basic oral health benefits to adults with IDD covered by Medicaid would take an investment but could dramatically change the oral health of this fragile population. Without action, this population of vulnerable adults will continue to suffer with untreated oral infection, inflammation, and pain.

NATIONAL DOWN SYNDROME CONGRESS
30 Mansell Court, Suite 108
Roswell, GA 30076

Statement of Chapman Bryant II, Policy and Advocacy Associate

The National Down Syndrome Congress (NDSC) is the country's oldest national organization for people with Down syndrome, their families, and the professionals who work with them. We provide information, advocacy and support concerning all aspects of life for individuals with Down syndrome, and work to create a national climate in which all people will recognize and embrace the value and dignity of people with Down syndrome.

NDSC thanks Senator Cardin (D–MD) and the entire United States Senate Finance Committee's Subcommittee on Health for holding a hearing to discuss the oral health crisis to identify and address health disparities. Individuals with Down syndrome face significant oral health challenges including issues with access and coverage of care with Medicaid, difficulties with self-care, medication side effects, and systemic health conditions.

The National Council on Disabilities (NCD) published a report entitled "Neglected for Too Long: Dental Care for People with Intellectual and Developmental Disabilities,"[1] highlighting the significant lack of dental care and access to oral health services for individuals with intellectual and developmental disabilities (IDD). The report highlights the critical need for increased awareness and action to address the oral health disparities faced by people with IDD. It notes that individuals with IDD are at a higher risk of developing oral health issues due to a combination of factors, including difficulties in self-care, medication side effects, and systemic health conditions. Found in the report, a series of studies concluded that 75% of dental students reported little to no preparation in providing care to people with IDD.

NDSC supports the information provided within these reports, and we hope the U.S. Senate Committee on Finance's Subcommittee on Health will take into consideration the severe oral health disparities facing individuals with Down syndrome. On top of these challenges, one of the biggest obstacles deals with the lack of access or coverage by Medicaid for people living with Down syndrome.

Furthermore, Medicaid may not cover all necessary oral health services for people with Down syndrome. For example, orthodontic treatment may not be covered, even though it may be essential for proper dental alignment and function. Additionally, Medicaid may not cover certain specialized services, such as sedation or general an-

---

[1] *https://ncd.gov/sites/default/files/NCD_Dental%20Brief%202017_508.pdf.*

esthesia, which may be necessary for individuals with Down syndrome who have difficulty tolerating dental procedures.[2]

Overall, these issues can lead to significant barriers in accessing oral health services for people with Down syndrome who rely on Medicaid for healthcare coverage. It is essential to address these issues to ensure that individuals with Down syndrome have equal access to quality oral health services and can maintain good oral health and overall well-being. If you have any questions, please contact Chapman Bryant, Policy and Advocacy Associate, at chapman@ndsccenter.org.

STATEMENT SUBMITTED BY RICHARD NORTH

My background is in non-profit health management, 21 years for the American Cancer Society, the last five as CEO of the Oregon chapter, and seven years as director of the Oregon Physicians for Social Responsibility's safe food program. I now volunteer with a large group of scientists, doctors and dentists all over North America to stop water fluoridation.

Everyone wants children and adults to have better dental health. The question is: What are the best ways to achieve that—and what ways actually do more harm than good?

I recommend taking the millions of dollars currently used for fluoridation to pay for improving access to low-income children to professional dental care—via mobile dental vans. They have a proven track record, especially when they can come to schools, thereby eliminating transportation problems for parents in getting their children to dentists and dental hygienists.

Mobile dental vans are a win-win-win situation. They can provide dental care for children whose parents currently don't have access to professionals, they reduce the health harms of fluoridation and they can be supported by everyone.

My opposition to fluoridation comes after 11 years of thoroughly researching the issue. It has two main foundations: health harms and ineffectiveness.

There is already a consensus (even including the CDC, one of fluoridation's main promoters) that fluoride's effectiveness in preventing cavities is mainly topical, not swallowed. Even if you accepted the CDC's questionable estimate that fluoridation reduces cavities by 25%, this only equates to 0.5 cavities per child, since children aged 6-17 average 2.1 cavities in their permanent teeth (Slade et al., *Journal of Dental Research,* 2018).

The Cochrane Collaboration is considered the gold standard of evaluating effectiveness. In its comprehensive 2015 review, it concluded "We did not identify any evidence . . . to determine the effectiveness of water fluoridation for preventing caries in adults. . . . There is insufficient evidence to determine whether water fluoridation results in a change in disparities in caries levels across socio-economic status."

Finally, World Health Organization data show cavity rates in children (age 12) have dropped as much in nations that don't fluoridate as in nations that do.

Bottom line: It's questionable if fluoridation has any effectiveness in preventing cavities, but if it does, it's very minimal. Please compare this to just one of many serious health harms connected with it, including endocrine disruption, kidney damage, diabetes, hypothyroidism, fluorosis and many others. I'd like to emphasize just one in more depth: permanent brain damage, especially loss of IQ.

We all know that air and water pollution disproportionately harm low-income and minority families, one of the worst examples the lead contamination in Flint, MI. And we all know there's no safe level of lead. Even the smallest amounts can cause permanent brain damage, especially lowered IQ.

But many do not know that recent studies, many funded by the National Institutes of Health, have found that fluoridated water can harm pregnant women and lower their children's IQs as much as lead.

Here are quotes from some of the world's top scientists:

---

[2] Medicaid Oral Health Coverage for Adults with Intellectual and Developmental Disabilities—A Fiscal Analysis, *https://ncd.gov/publications/2022/medicaid-oral-health-coverage-adults-IDD.*

Dr. Philippe Grandjean, Harvard professor and author of 500 peer-reviewed papers: "Fluoride seems to fit in with lead, mercury and other poisons that cause chemical brain drain."

Dr. David Bellinger, researcher who has authored over 100 studies on lead: "It's actually very similar to the effect size that's seen with childhood exposure to lead."

Dr. Dimitri Christakis, pediatrician and co-editor of the *Journal of the American Medical Association Pediatrics:* Fluoridation is, quote, "an effect size which is sizeable—on par with lead." He also said if his wife were pregnant, "I would not have my wife drink fluoridated water."

Moreover, a recent National Toxicology Program review found that 52 out of 55 studies linked higher fluoride with substantially lowered IQ, including 18 out of 19 rated the highest quality. It said, "Several of the highest quality studies showing lower IQs in children were done in optimally fluoridated (0.7 parts per million) areas."

Contrast this massive scientific evidence to assertions of the two major promoters, the CDC and American Dental Association, that fluoridation is safe for everyone. That's just not true.

It's especially unfair for low-income families, who can't afford bottled water or expensive filters to avoid this brain damage. *They have no choice.* Fluoride is every bit as much an environmental injustice as Flint and far more widespread—it's contaminating three fourths of our public water supply.

Please, stop this unscientific, unjustified practice from further harming our pregnant women and children. Let's turn this negative situation into a positive one.

Thank you for your consideration.

ORAL HEALTH ALLIANCE
1150 18th Street, NW, Suite 910
Washington, DC 20036
202–659–1858
www.oralhealthalliance.org

U.S. Senate
Committee on Finance
Subcommittee on Health Care

Chairman Benjamin Cardin, Ranking Member Steve Daines, and distinguished members of the Senate Finance Committee, Subcommittee on Health Care thank you for holding this hearing on the important topic Oral Health Crisis: Identifying and Addressing Health Disparities. I am Nancy Chapman, MPH, RD, a public health nutritionist who has managed the Oral Health Alliance (OHA), a Healthy People 2030 Champion, over the past six years. I will present recommendations for oral health preventive practices to help forestall and reverse this country's oral health crisis. Our informal Alliance represents oral health providers, nutrition and public health professional organizations, nutrition and dental researchers at dental schools nationwide, groups representing children and older adults, industry, and school-aged and community groups interested in addressing disparities in the prevalence and prevention of dental caries throughout the United States. The OHA focuses on preventive oral health practices, especially for under-resourced communities, that often get overlooked in policy discussions focused on oral health treatment services and reimbursement of those services.

The OHA agrees with comments made at your March 29th hearing that pointed to the need to increase family literacy about the essential role that poor oral health plays in overall health deficits across the life span. To prevent dentsnacks andarly, the OHA urges instruction of pregnant women, young children, new parents, and caregivers about preventive practices to follow throughout the lifespan—decreasing frequent intakes of foods high in fermentable carbohydrates, brushing teeth, cleaning between teeth, chewing sugar free gum for 20 minutes after meals or snacks, and drinking fluoridated water or using fluoridated toothpaste and fluoride tablets. For vast number of communities underserved by dental practices, education about preventive oral health practices can be delivered through telehealth channels, mobile health units, in schools, early childhood education centers, older American centers, workplaces, farm worker communities, and other sites that were identified by other hearing witnesses. Dental caries is completely preventable with access to proper knowledge about dental hygiene, access to adequate healthy foods, access to

affordable oral health tools, such as toothbrushes, fluoridated toothpaste, dental floss, and sugar free gum, and access to fluoridated water or tablets. Compared to expenditures on emergency dental services, preventive services are affordable and inexpensive.

Why support preventive oral health practices? The answer is that poor oral health is a silent epidemic that impacts those who are food insecure, underinsured, underresourced, and isolated. Poor oral health has a disproportionate health and economic impact on the healthcare system, society, and families. About 18 percent of children under 6 have dental caries climbing to 45 percent of those children aged 6–11 that have at least one decayed tooth. 1 in 6 adolescents have untreated tooth decay, and I in 6 adults aged 65 or older have lost all their teeth. If tooth decay remains untreated, it can affect nutritional intake and lead to tooth loss and severe health and mental complications. In the US alone, the 2021 cost of highly preventable dental care cost nearly $162 Billion. Medicare and Medicaid spent about $4 billion. Private spending was up $11 billion and out-of-pocket up $13 billion from 2020–2021, according to American Dental Association data. On average, 34 million school hours are lost annually due to unplanned/emergency dental care needs; and more than $45 billion (US dollars) are lost each year in productivity because of untreated oral disease.

Oral health and nutrition have a multifaceted-relationship—oral infectious diseases, including dental caries, impact the ability to eat healthy foods that meet the Dietary Guidelines for Americans (DGAs) and nutrition status across the life span, and nutrition and diet can affect the development and integrity of the oral cavity and progression of oral diseases. Social and economic conditions are important determinants of oral health. Over the past five years, the OHA members have offered evidence on the benefits of preventive oral health practices and information on how professionals and communities are implementing oral health prevention programs to leaders and experts within ODPHP, CDC, CMS, HRSA, and NIDCR as well as USDA. The OHA website, *https://oralhealthalliance.org/,* contains copious links to research across life stages and for each preventive oral health practice.

We continuously share extensive scientific evidence and public health justification for including affordable and feasible advice on preventive oral health practices in the 2025–30 DGAs. Specifically, we recommend all health and nutrition policies highlight five key practices ? to decrease frequent intakes of foods high in fermentable carbohydrates, to brush teeth, to clean between teeth, to chew sugar free gum for 20 minutes after meals or snacks, and to drink fluoridated water or use with fluoridated toothpaste or fluoride tablets.

In past few years, several major reports have been published that confirm the increasing domestic and global concern about the health inequity of untreated dental caries and its impact on dietary intake, health, and prevalence of chronic disease.

January 2023—WHO Oral Health Action Plan recommended taking a public health approach that provides services that include oral health promotion and prevention as well as treatment and rehabilitation interventions related to oral diseases and conditions across the life course. The Plan stated that achieving the highest attainable standard of oral health is a fundamental right of every human being. The WHO stated that "Oral health affects people physically and psychologically and influences how they grow, enjoy life, look, speak, chew, taste food and socialize, as well as their feelings of social well-being."

November 2022—National Academies of Science, Engineering, and Medicine (NASEM) workshop, Sharing and Exchanging Idea and Global Experiences on Community-engaged Approaches to Oral Health, focused on the new WHO and FDI World Dental Federation definition of oral health as vital to general health and well-being and on approaches to community-engaged oral health.

December 2021—NIDCR Oral Health in America: Advances and Challenges reiterated the link between oral health and overall health, identified safe and effective measures and dietary changes to improve oral health, and addressed four of the top chronic diseases related to oral health.

December 2020—the HP 2030 Oral Health Objectives, included 15 of the 358 health objectives, recognized the growing problems of untreated dental caries and their impact on dietary intake, health, and prevalence of chronic diseases of individuals across the life span, especially from under-resourced communities, due to social and economic conditions.

December 2020—the 2020–2025 Dietary Guidelines for Americans (DGAs) recognized "dental caries as one of the diet-related chronic diseases that pose a major public health problem for Americans." The DGAs stated: "Good dental health is essential to overall health as well as the ability to chew food properly."

With the opportunity to prevent the substantial problems of dental caries and related chronic diseases, federal agencies should widely disseminate messages, program, and policies promoting the benefits of adopting routine oral health practices in educational materials for millions of Americans suffering from, or at risk for, dental caries, especially those with social and economic challenges. The 2025–2030 DGAs, under development by the Dietary Guidelines Advisory Committee (DGAC), is a primary public health document, recognized worldwide, that should carry forward advice to decrease frequent intakes of foods high in fermentable carbohydrates, brush teeth, clean between teeth, chew sugar free gum for 20 minutes after meals or snacks, and drink fluoridated water. The OHA requests the Senate Finance Committee leaders send a letter to the Secretaries of HHS and USDA strongly encouraging the DGAC review the evidence supporting specific preventive oral health practices and request their inclusion in the 2025–2030 DGAs recommendations. Thank you for this opportunity to share the recommendations of thousands of individuals that work to correct the oral health crisis through multiple channels.

ORAL HEALTH PROGRESS AND EQUITY NETWORK
https://openoralhealth.org/
https://communities.openoralhealth.org/s/

March 29, 2023

The Honorable Chuck Schumer
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
Washington, DC 20510

Dear Leader Schumer and Leader McConnell:

As you embark on the 118th Congress, we urge you to prioritize a policy change to improve oral health in America: **extending guaranteed, comprehensive dental coverage to all adults who rely on Medicaid for their health care.** Poor oral health hurts more than our mouths. It can impede an equitable and lasting economic recovery by harming our overall health, employability, and financial security. By securing Medicaid dental coverage for adults, Congress can drive health and economic gains for families, states, and our nation.

We urge you and your colleagues to cosponsor and work to advance the Medicaid Dental Benefit Act (S. 570/H.R. 1342), led by Senator Cardin and Congresswoman Barragàn in their respective chambers, which would make comprehensive dental care a mandatory component of Medicaid coverage for adults in every state. As detailed below, ensuring Medicaid adult dental coverage is vital to advancing racial and economic equity; supporting employment and economic growth; improving people's overall health; and protecting our health care resources.

Oral health coverage is a glaring hole in Medicaid benefits that are otherwise a lifeline to millions of adults and families. Adult dental coverage is optional for state Medicaid programs. While children enrolled in Medicaid have guaranteed, comprehensive dental benefits, federal policy does not have similar standards for adults who rely on the program. As a result, oral health coverage for adults varies widely across states, and some states don't cover it at all. This puts care out of reach for millions of people, especially given that adults with low incomes confront the greatest cost barriers to oral health care out of any age or income group. In fact, cost barriers to dental care for adults have only increased [1] in recent years, with Black and Hispanic communities reporting the highest financial hurdles to accessing the care they need.

Adding adult dental coverage to Medicaid is key to advancing racial, economic, and health justice. Lack of access to dental care is one of the most overlooked examples of health disparities today. America's entrenched racial and economic inequities risk individual and community well-being. The very people who are also most likely to get sick or lose their job from health and economic crises also

[1] *https://familiesusa.org/wp-content/uploads/2021/07/HPI-CC-FUSA-WhitePaper_0721.pdf.*

face the steepest structural and historic barriers to dental services: people with low incomes; Black, Hispanic, and other people of color; tribal communities; people with disabilities; and those in rural America, among others.

Without access to affordable dental care, these communities are more likely to have poor oral health. For example, among adults facing cost barriers to dental care, racial disparities[2] have widened in the last decade. Securing Medicaid oral health coverage for adults could alleviate needless suffering while also advancing equity.

When policy and cost barriers keep dental care out of reach, it threatens national prosperity. For many adults, being able to afford dental care could be the key to getting a new job or supporting their economic security. Yet three in ten working-age adults with lower incomes say that the appearance of their mouth and teeth affects their ability to interview for a job.[3] The U.S. loses more than $45 billion each year in productivity[4] due to untreated dental disease.

Research shows, however, that Medicaid adult dental coverage can improve employability,[5] while reducing associated racial inequities in the job market. Good oral health can also increase wages[6] for women in the workforce. These gains could be pivotal for people recovering from pandemic unemployment, which most hurt women and women of color.

Expanding oral health coverage is a cost-effective way to support better health at every age. Lacking access to dental care risks our overall health and wastes resources. Poor oral health can make chronic conditions, like diabetes, more difficult and expensive to manage. It may also cause dangerous and costly pregnancy complications, with risks to parents and children. But analysis[7] by the ADA Health Policy Institute, Community Catalyst, and Families USA finds that extending Medicaid adult dental benefits could lead to significant savings: With improved oral health, the policy could save at least $273 million annually in medical costs related to diabetes, heart disease, and pregnancy. It could also lower overall state spending on dental care.

The research, however, does not account for other key savings this policy would yield over time, meaning that the estimated price tag of $535 million in federal spending is likely higher than what we would see in reality. For example, greater access to dental care would reduce other unnecessary health spending, such as averting hospital emergency department visits for dental pain. This could save the U.S. health system $2 billion[8] per year.

A growing number of experts and community leaders support lifting barriers to dental coverage. Building upon decades of work on this issue at the state and national levels, community leaders, health equity advocates and oral health stakeholders have actively voiced our support[9] for Medicaid oral health coverage to the Biden-Harris administration and Congress. For nearly a decade, the American Dental Association[10] has also publicly supported making adult dental coverage a mandatory Medicaid benefit. We are encouraged by the President's FY 2022 budget, which recognizes the value of dental coverage in its proposal to add this benefit to Medicare. At the same time, policymakers must not neglect adults with low incomes who count on Medicaid.

Congress can and must advance federal policy that makes comprehensive oral health coverage for adults a permanent part of the Medicaid program for all states. Continuing to make dental coverage inaccessible for some communities, including people of color, tribal communities, and adults with low incomes, harms us all. Oral health shapes our overall health and shared prosperity, and will influence the direction of our recovery from the pandemic.

By advancing the Medicaid Dental Benefit Act, lawmakers can promote a sustainable economic recovery and reduce vast health inequities by guaranteeing dental coverage to all adults who count on Medicaid, no matter where they live.

---

[2] *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0421_3.pdf.*
[3] *https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/us-oral-health-well-being.pdf.*
[4] *https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm.*
[5] *https://onlinelibrary.wiley.com/doi/abs/10.1111/jphd.12447.*
[6] *https://www.jstor.org/stable/25703463?seq=1.*
[7] *https://familiesusa.org/wp-content/uploads/2021/07/HPI-CC-FUSA-WhitePaper_0721.pdf.*
[8] *https://familiesusa.org/wp-content/uploads/2021/07/HPI-CC-FUSA-WhitePaper_0721.pdf.*
[9] *https://drive.google.com/file/d/1jLqcuQACxIQSex7EAzYQs7qmwxFsUbdM/view.*
[10] *https://www.ada.org/about/governance/current-policies#medicaidchip.*

Thank you for your consideration.

Sincerely,

34th Legislative District Democrats, Healthcare Caucus
7 Dimensions Outreach
ACA Consumer Advocacy
Achieva/Disability Healthcare Initiative
Ajo Community Health Center
Alabama Arise
Alliance for a Healthy Kansas
AltaMed
American Academy of Pediatric Dentistry
American Children's Campaign
American Dental Association
American Dental Hygienists' Association
American Institute of Dental Public Health
American Network of Oral Health Coalitions (ANOHC)
Apple Tree Dental
Arcora Foundation
Arizona oral health coalition
Asian Resources, Inc.
Association of State and Territorial Dental Directors
Ayuda Smiles, Inc. dba Smiles For Veterans
Bleeding Disorders Association of South Carolina
Bowling Business Strategies
California Pan-Ethnic Health Network
Caly County Public Health Center
CareQuest Institute for Oral Health
Catalyst Miami
Center for Medicare Advocacy
Central Florida Jobs With Justice
Charles County Department of Health
Children's Action Alliance
Children's Oral Health Network of Maine
Coalition of Texans with Disabilities
Coastal Bend Oral Health Coalition
Community Catalyst
Community Dental Health
Community Health Foundation
Connecticut Oral Health Initiative, Inc.
Consumers for Affordable Health Care
Delta Dental of Colorado Foundation
Dental Diversity and Inclusion Alliance
Dental Trade Alliance
Families USA
Family Connection of SC
Florida Health Justice Project
Florida Policy Institute
Floridians For Dental Access
Georgians for a Healthy Future
Grand Avenue Dental
Hawai'i Oral Health Coalition
Hawaii Children's Action Network
Health Care For All
Health Law Advocates
Healthcare For All—South Carolina
Healthy Mothers Healthy Babies Coalition of Georgia
HIV Dental Alliance
Hoosier Action
Idaho Oral Health Alliance
Illinois Primary Health Care Association
JBRR Consulting
Justice in Aging
Katy Trail Community Health
Kennebec Valley Family Dentistry
Kentucky Equal Justice Center
Kentucky Voices for Health
Kids in Need of Dentistry (KIND)

Knox Clinic
Latino Communications CDC
Liberty Dental Plan
Louisiana Budget Project
Luxury Tooth Booth Inc.
Maine Chapter, American Academy of Pediatrics
Maine Council on Aging
Maine Equal Justice
Maine Primary Care Association
Maine Public Health Association
MaryCatherine Jones Consulting, LLC
Maryland Citizens' Health Initiative
Maryland Dental Action Coalition
Michigan League for Public Policy
Ministerial Health Fellowship Advocacy Coalition
Mississippi Health Advocacy Program
Missouri Coalition for Oral Health
More Smiles Wisconsin, Inc.
NAACP South Carolina State Conference
NAMI SC
National Association of Dental Plans
National Interprofessional Initiative on Oral Health
National Rural Health Association
Nebraska Appleseed
New Hampshire Oral Health Coalition
New Hampshire Public Health Association
New Jersey American Dental Hygiene Association
New Jersey Citizen Action
New Mainers Public Health Initiative
NH ACP
NHAAP
NHAFP
NHPS
North Seattle Progressives (NSP)
Northwest Health Law Advocates
Northwest Health Law Advocates (NoHLA)
Ohio Federation for Health Equity and Social Justice
Ohio Grandparent Kinship Coalition
Oklahoma Policy Institute
Oral Health Kansas
Oral Health Nursing Education and Practice (OHNEP)
Oral Health Ohio
PA Coalition for Oral Health
Pacific Northwest University of Health Sciences—School of Dental Medicine
Palmetto Project, Inc.
Paraquad, Inc.
Partnership for Southern Equity
Penn Dental Medicine
Pennsylvania Health Access Network
Project Accessible Oral Health
San Fernando Community Health Center
San Joaquin Public Health Services—Local Oral Health Program
Santa Fe Group
Saratoga Immigration Coalition
SC Appleseed Legal Justice Center
SC Christian Action Council
Shriver Center on Poverty Law
Solid Ground
South Dakota Voices for Peace
Southern Vermont Area Health Education Center
SPACEs In Action
Special Access Dental
Statewide Poverty Action Network
Strategic Concepts in Organizing and Policy Education (SCOPE)
Temporary Dental
Tennessee Disability Coalition
Tennessee Health Care Campaign
Tennessee Justice Center

Texas Oral Health Coalition
The Arc SoMD
The Bingham Program
The Gerontological Society of America
The JAYCEES of Rhode Island
Two Step Dental
U.S. Committee for Refugees and Immigrants
United Way for Southeastern Michigan
University of South Alabama
Utah Health Policy Project
UUHFCT
Virginia Dental Association Foundation
Virginia Health Catalyst
Virginia Interfaith Center for Public Policy
Virginia Organizing
Virginia Poverty Law Center
Voices for Vermont's Children
Washington Dental Access Campaign
Washington Poor People's Campaign
West Virginians for Affordable Health Care
WVU School of Dentistry
Wyoming Public Health Association

LETTER SUBMITTED BY BILL OSMUNSON, D.D.S., MPH
Smiles of Bellevue
American Environmental Health Studies Project

March 29, 2023

U.S. Senate
Committee on Finance
Subcommittee on Health Care

Dear Senator Benjamin Cardin, Steve Daines and the Senate Finance Health Care Subcommittee:

Thank you for having a hearing on Oral Health. Oral health is often considered elective because few die from it. However, oral pain and disease can be debilitating and life altering. Disparities, some caused by authorities, are a concern and can be attenuated.

I am a practicing dentist with 49 years of experience in disadvantaged rural communities, the wealthiest communities, managed care, Indian Health Service, private practice and as an educator to and with the finest cosmetic dentists in the world. My two professions, dentistry and public health are dear to my heart. With your help we can do better. Your witnesses were not practicing dentists and lacked expressing real world experience.

Summary: Educating more minority dentists, even financial incentives to those dentists to go to underserved communities, and then paying them below the cost to treat the disease will help some with limited success. Either quality goes down, unnecessary work is done, or the dentist moves to where they can survive financially.

Governments and "authorities" are contributing to hundreds of Billions of dollars in harm and poorly spent resources while lowering income, contributing to oral health damage, and minorities end up taking a disproportionate share of the harm.

Witnesses called by the committee are part of the choir and the Senators failed to gain significant alternatives to recommendations for "more of the same." Alternatives to some of our policies have been shown to be effective in other countries. The hardest part is objective evaluation of what we are doing, what we want, and the science to get there.

Examples:

1. Public health authorities based on political pressure must stop overruling the science experts. Government funding continues to promote the flawed policies and protect entrenched turf.
2. Protecting the public and minorities, the fetus and infants must become the priority. Governments are investing millions into harming the public which is

causing billions of dollars of harm. Toxins such as mercury treatments and fluoride ingestion should not be supported.

3. Health education must become a priority, rather than pharmacology and surgery. Pumping patients through dental "surgical factories" to treat disease does little to educate the public on how to prevent the disease.
4. When hearings are set up, divergent voices should be heard, including clinical dentists.

Specifics: Health and Human Services (HHS) blocked the National Toxicology toxicologists' report on Fluoride's developmental neurotoxicity from being released, until the court forced HHS to release the report. The NTP experts have been silenced, their report white -washed, so the policies, rather than the public, can be protected.

Centers for Disease Control Oral Health Division (CDC) is little more than a rubber stamp for industry.

The American Dental Association (ADA) testified in court they have no duty to protect the public. The ADA protects dentists first and foremost, not the public. The Senate must be inclusive of organizations more protective of the public health such as the International Academy of Oral Medicine and Toxicology.

The EPA has and is over-ruling their scientists and the National Research Council to protect policy and tradition. For example, the EPA scientists have clearly spoken through their Union:

> In summary, *we hold that fluoridation is an unreasonable risk.* That is, the toxicity of fluoride is so great and the purported benefits associated with it are so small—if there are any at all—*that requiring every man, woman and child in America to ingest it borders on criminal behavior on the part of governments.* Dr. J. William Hirzy, Senior Vice-President, Headquarters Union, U.S. Environmental Protection Agency, March 26, 2001

Although the EPA scientists are opposed to fluoridation, the EPA management overrules the scientists.

We have taken the EPA to court under the Toxic Substances Control Act. The EPA did not provide their experts to testify in court in support of EPA's policies on fluoride. Instead, EPA hired an outside company known for protecting industry, such as tobacco. The public's health must come before twisting evidence. EPA scientists are good, the management is the problem.

The legal counsel of the FDA reports jurisdiction for water is with the EPA. The EPA legal counsel reports the FDA has jurisdiction over the drug fluoride. In effect, no Federal Agency assumes jurisdiction over determining the dosage, pharmacological efficacy, adverse effects, label, total exposure from all sources at all ages, safety, harm, ethics or benefit—if any.

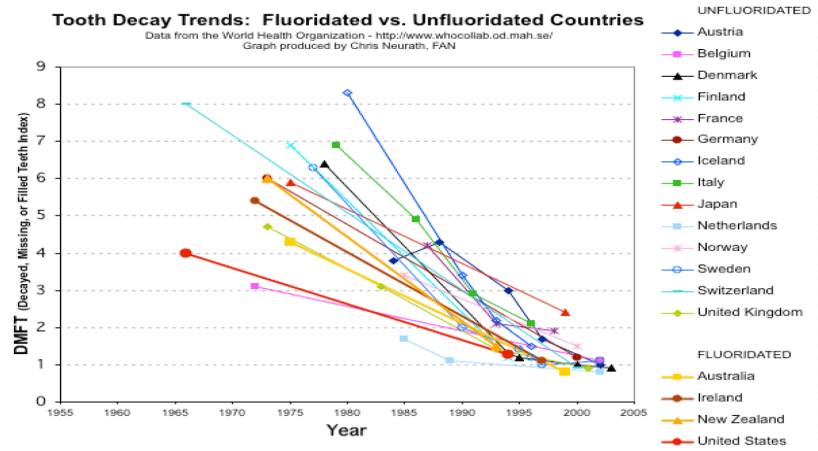
Your witness, Dr. Cherae Farmer-Dixon was clear and correct in that diagnosis and treatment of oral health has improved, but "it has not been equitable." Oh. . . and what about prevention? Ignored.

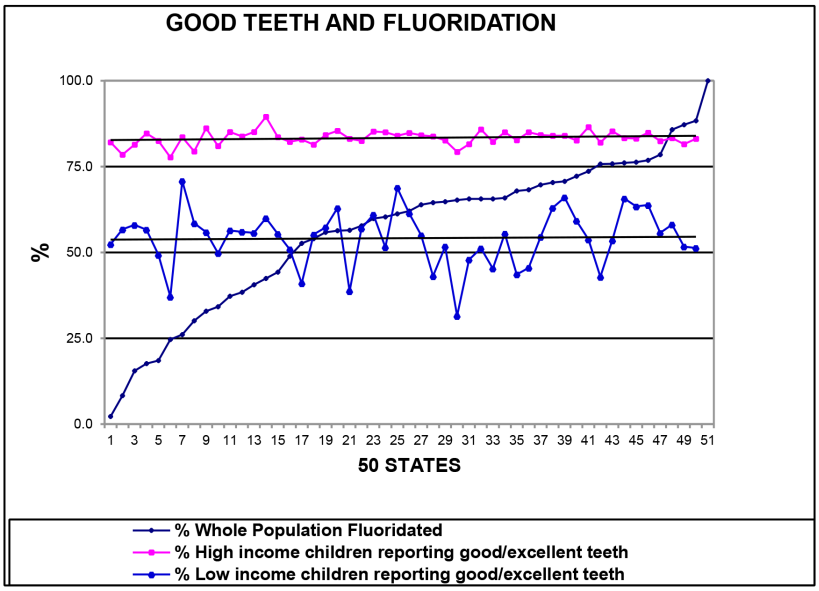
Consider the following graphs from published research.

World Health Organization data graphed and published by Neurath clearly shows a decline in dental caries in all developed countries regardless of chosen policies or fluoridation. We should celebrate improved success in oral health, in developed countries.

Caries rates are declining especially for the wealthy. I published the graph below ranking the USA states on the percentage of their whole population on fluoridated water and percentage reported good/excellent teeth (National Survey of Children's Health data).

The data is powerful. Fluoridation has no common cause with oral health, but income (socioeconomics) has a significant effect on oral health. If public health fluoridation actually reduced dental caries we should see and measure a benefit in the community at large. But we don't.





Fluoride ingestion lowers IQ. Lower IQ results in lower income, increased incarceration, more special education and lower socioeconomics. The Food and Drug Administration historic position not to ingest fluoride is supported with hundreds of published research studies. Authorities pushing fluoridation are relying on outdated evidence.

Prevention is better than treatment and will improve health and reduce socioeconomic disparities; however, relying on chemistry to overcome bad habits is not wise. The first item to eliminate in the dental practice when reimbursement goes down, is prevention. No more diet instruction, oral hygiene instruction, handing out tooth brushes, tobacco harm or avoiding substance abuse.

Our oral health care system has set up great "repair shops;" however, prevention is not profitable and marginalized in part to the rich. Don't get me wrong, we need to treat those in pain and stop the pathology from getting worse, but we are not

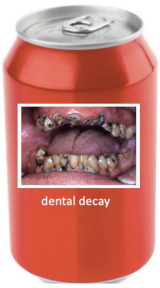
maximizing prevention because CDC and HHS and ADA are focused on flawed data of fluoride ingestion, diagnosis and treatment.

We have alternative opportunities.

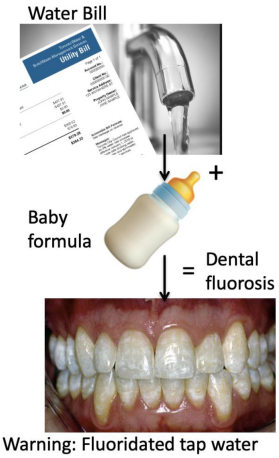
1. Stop sugar subsidies. Tax the sources causing harm. With tobacco we educate the harm on the label. Require soda pop cans to have pictures of damaged teeth, such as Dr. Limeback's suggestion on health education.

ALL consumer products that are known to harm should have warning pictures showing the health consequences

World Health Organization warning that smoking doubles the risk of stroke (some warning pictures are already on cigarette packages in many countries)



Warning: Excessive consumption of soda pop with sugar can cause dental cavities



Warning: Fluoridated tap water causes dental fluorosis

2. Tobacco sales are taxed. Soda and sugar products should also and the money spent on health education and treatment of the damage it causes. Government sugar subsidies must stop.

WHO recommends soda taxes to reduce sugar consumption and has some effect on socioeconomic inequalities.

3. More dentists are not the answer for disparities. Dentists move to where they can have economic stability and success.

Do not marginalize lower socioeconomic individuals to mass factory assembly line dental factories which provide incomplete low-quality diagnosis and treatment.

4. Like Europe, the precautionary principle should be accepted.

Taking a project out to bid is the normal process for procurement, but is lacking in oral health. Governments expect dentists to provide treatment below costs. Moving to distressed communities to provide quality oral health prevention, diagnosis and treatment at "below costs" is not appealing to most dentists.

I would be willing to provide more evidence, but my experience with authorities is they have their minds made up before hearings and trust those whom they have trusted in the past. If anyone is reading this, please confirm with an email to bill@teachingsmiles.com.

Sincerely,

Bill Osmunson, D.D.S., MPH

PATIENT ACCESS NETWORK FOUNDATION
805 15th Street, NW, Suite 500
Washington, DC 20005
https://www.panfoundation.org/

Statement of Kevin L. Hagan, President and Chief Executive Officer

Chairman Cardin, Ranking Member Daines, and members of the subcommittee, thank you for convening this hearing to put a spotlight on the unequal access to oral health care that some racial/ethnic and socioeconomic groups experience. We urge your subcommittee to take action on this important issue that impacts people's overall health, ability to work and ability to attend school.

PAN is an independent, national 501(c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic, and rare diseases with the out-of-pocket costs for their prescribed medications. PAN provides patients with direct assistance through nearly 70 disease-specific programs and collaborates with national patient advocacy organizations to provide patients with education and additional support. Since 2004, we have helped more than 1 million underinsured patients gain access to their lifesaving prescriptions.

PAN supports improving oral health and hygiene as an integral part of health care. As you know, poor oral health and hygiene can cause tooth decay, gum disease and tooth loss among a variety of other health complications. Populations with a greater oral health risk include individuals with chronic diseases and weakened immune systems. Insufficient or inadequate dental care can worsen chronic health problems like diabetes and cardiovascular disease, hinder timely diagnosis of severe medical conditions, and lead to avoidable complications that may require costly emergency room visits.[1]

While access to oral health has improved for many Americans there continues to be disparities in access. In the United States, people are more likely to have poor oral health if they are low-income, uninsured, and/or members of racial/ethnic minority, immigrant, or rural populations who have suboptimal access to quality oral health care. These inequities extend throughout the life course and include differences in access to affordable healthy foods, professional dental prevention and treatment services, and dental insurance.[1] These same groups are less likely to afford to pay out-of-pocket for dental care, do not have private or public dental insurance, or can't get time off from work to get to dental care. Dental expenses constitute more than a quarter of overall health care out-of-pocket (OOP) expenditures and are reported to present higher financial barriers than medical, prescription pharmaceuticals, and mental health care.[2]

As you know, the Medicare program covers a majority of all Americans age 65 and older and plays a vital role in the quality and longevity of their lives. However, the program has also long fallen short in providing those beneficiaries with sufficient coverage for essential oral and dental treatment. Two-thirds of Medicare beneficiaries lack oral health coverage, and 49% of Medicare beneficiaries have not seen a dentist in the last 12 months (as of 2017).[3] A recent study found that use of dental services fell at age 65 for both enrollees in tradition fee-for-service and Medicare Advantage.[4] As a result, medical problems and treatment that can be proactively addressed with such care have instead gone unchecked, delayed, or canceled, resulting in serious clinical, human, and fiscal implications.

All too often, limited or no dental insurance coverage can result in high OOP or foregone oral health care. High OOP costs are a barrier to dental care as more than 15 million older adults live on incomes below 200% of the federal poverty level, and 4.7 million live below poverty. Forgoing dental care, however, can worsen underlying conditions. Untreated cavities and gum disease can exacerbate certain diseases,

---

[1] Oral Health in America: A Report of the Surgeon General. U.S. Department of Health and Human Services, *https://onlinelibrary.wiley.com/doi/epdf/10.1111/jcpe.12060.*

[2] Vujicic M, Buchmueller T, Klein R. Dental care presents the highest level of financial barriers, compared to other types of health care services. *Health Affairs.* 2016a;35(12):2176–82, *https://doi.org/10.1377/hlthaff.2016.0800.*

[3] Kramarow EA. Dental care among adults aged 65 and over, 2017. NCHS Data Brief, No 337. Hyattsville, MD: National Center for Health Statistics. 2019, accessed at: *https://www.cdc.gov/nchs/products/databriefs/db337.htm.*

[4] Simon, L., Song Z., and Barnett, M., Dental Services Use: Medicare Beneficiaries Experience Immediate And Long-Term Reductions After Enrollment, *Health Affairs,* Vol. 42, No. 2, February 2023, *https://doi.org/10.1377/hlthaff.2021.01899.*

such as diabetes and cardiovascular disease, and lead to chronic pain, infections, and loss of teeth.

PAN urges the Committee to authorize a dental benefit in Medicare so that millions of beneficiaries on fixed incomes will be able to maintain their oral health that is critical to their overall health. Importantly, Congress must structure the benefit to included routine preventive procedures and limit out-of-pocket spending for more invasive dental care, including restorative procedures such as fillings, crowns and root canals. High levels of coinsurance have proven to be cost prohibitive and results in a drop in utilization of dental services.[3]

In the absence of a dental benefit, PAN is pleased that the Centers for Medicare and Medicaid Services (CMS) included in the 2023 Physician Fee Schedule final rule clarification of medical coverage for dental services that are inextricably linked and substantially related and integral to organ transplant surgery, cardiac valve replacement, valvuloplasty procedures, and head and neck cancers. The final rule also created the opportunity for further coverage of procedures by establishing "a process to identify for consideration and review submissions of additional dental services that are inextricably linked and substantially related and integral to the clinical success of other covered medical services." PAN urges the committee to utilize its oversight of CMS and engage with CMS officials as they formulate the 2024 Physician Fee Schedule proposed rule.

PAN lauds you for your continued leadership to increase access and affordability of oral health care. We welcome the opportunity to work with the Committee as they develop legislation to address this important issue. For further information, please reach out to Amy Niles, Chief Advocacy and Engagement Office at aniles@panfoundation.org.

PERSONAL ORAL HYGIENE
6847 E. 40th Street
Tulsa, OK 74145
Office: 918–622–9412
800–331–4645
https://buypoh.com/

March 28, 2023

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington DC 20510-6200

To Whom It May Concern,

I write to inform that there is a little known school of Dentistry, one that actually lessens the burden of tooth decay and gum disease in their patients. Known as Preventive Dentist's, this school, for over 70 years, has seen the oral health of their patients improve, and stay healthy.

Today, the business of Dentistry charges the America public over $125 billion per year to treat these two diseases. This is a perverse incentive that precludes the prevention of tooth decay and gum disease.

This does not speak to the myriad commercial determinants of ill health, billions of dollars of mouthwash, toothpaste, and other useless sundry items being sold to hopeful people that do not work as advertised.

There is an unhealthy relationship between organized Dentistry and the companies that sell these goods.

Tooth decay is the number one disease of childhood, all of Dentistry will tell you that tooth decay is preventable, and this is the disconnect.

If any of the nostrums sold to prevent tooth decay and gum disease, including those offered by organized Dentistry today, actually prevented anything, we would see a decrease in the number of Dental schools, but we see the opposite.

Since at least 1971, organized Dentistry has promoted only two things for the prevention of tooth decay and gum disease. This abject dependency has led to the dire conditions we see today.

Over 500 million tax dollars were given to the National Institute of Dental and Craniofacial Research in 2022. Never take advice from a bald headed barber on how to grow hair.

To the oral health of the Nation,

Robert G. Jones II
President
Oral Health Products, Inc.

STATEMENT OF MARJORIE SHAPIRO

It's time that all our government health agencies stop promoting chemical water fluoridation.

Fluoridation chemicals that are added to drinking water are unpurified toxic waste from industry. Hydrofluorosilicic acid (HFS) is transported around the country in hazmat certified trucks and by rail. Recently a train derailment of hazardous material caused a disaster in East Palestine PA which would have been an even bigger disaster had the train been carrying HFS. HFS is highly toxic, highly flammable, and extremely dangerous to transport. The disaster in East Palestine should be a wake-up call.

Not only are fluoridation chemicals toxic, corrosive and dangerous to transport, but, by definition, fluoride is a drug. It is added to supposedly treat the disease of dental decay. Millions of Americans are forced to consume fluoride daily, a drug that isn't even pharmaceutical grade; that is given without informed consent and without regard to dosage. No one is monitoring how much fluoride a person is ingesting. If someone drinks a lot of black tea which contains fluoride, takes drugs such as Prozac that contain fluoride or if they sweat a lot and drink copious amounts of water, they are consuming an unknown dose.

Every tube of toothpaste has a poison warning to not swallow it. Toddlers and young children who are too young to spit it out swallow toothpaste. No one is monitoring how much toothpaste is on the brush and how much a child swallows. Numerous high-quality, peer reviewed studies now show neurologic harm to fetuses, infants, and children from exposure to fluoride. We need to protect our most vulnerable from harmful chemicals.

Fluoride is the only chemical added to water that is not added to treat the water to make it potable. Only fluoridation chemicals are added to treat people. In defiance of the Safe Drinking Water Act, EPA allows fluoridation chemicals which contain both lead and arsenic into drinking water. EPA's maximum contaminant level goal for lead and arsenic is zero.

Any benefit to teeth from fluoride is topical. Brush your teeth with it, opt in or out of a fluoride treatment at the dentist but toxic, corrosive fluoridation chemicals should not be transported across the country and dumped into drinking water. US Citizens have a right to pure unadulterated drinking water without any amount of added lead, arsenic, heavy metals, radio-nuclides and drugs such as fluoride.

LETTER SUBMITTED BY KAREN FAVAZZA SPENCER

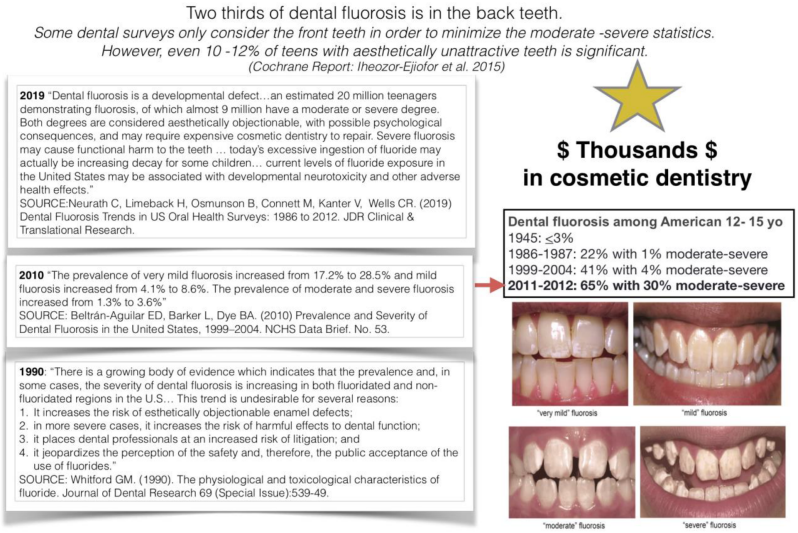
March 29, 2023

U.S. Senate
Committee on Finance
Subcommittee on Health Care

> By focusing on fluoridation instead of diet and dentist-access, organized dentistry allowed a national dental health crisis to occur on its watch and created a new one—dental fluorosis.
>
> —Dr. David Kennedy, D.D.S., MPH, 3rd generation dentist and past president of the International Academy of Oral Medicine (2016)

To Whom It May Concern:

I suggest that the comment by Dr. David Kennedy quoted above is about as pithy as it gets. But allow me to provide you with a picture with additional quotes and scientific references to demonstrate.



* Dental Fluorosis costs the individual thousands, the community millions & fuels the **multi-billion** dollar cosmetic dentistry industry.
** Statistics from U.S. National Health and Nutrition Examination Surveys (NHANES)

But if the crass profiteering of various fluoridation stakeholders that is facilitated by willfully blind decision makers isn't enough, let's consider the March 2023 revelations that biased actors in Health and Human Services (HHS), egged on by the Oral Health Division of the CDC whose paychecks are connected to fluoridation promotion and programs, managed to use political means to suppress a National Toxicology Report (NTP) that validated that any exposure to fluoride in utero or during infancy is indeed associated with lower IQ as well as increased rates of other cognitive-behavioral deficits and dental damage.

Here is the link to the NTP webpage that was only released because of a whistleblower and court order: *https://ntp.niehs.nih.gov/whatwestudy/assessments/noncancer/ongoing/fluoride/index.html.*

> Several of the highest quality studies showing lower IQs in children were done in optimally fluoridated (0.7 mg/L) areas in Canada, but the individual exposure information in those studies, as documented by repeated urinary measurements, suggests widely varying total fluoride exposure from drinking water combined with exposures from other sources. For example, many urinary fluoride measurements exceed those that would be expected from consuming water that contains fluoride at 1.5 mg/L.
>
> —NTP reply to HHS comment re NTP Report (March 15, 2023)

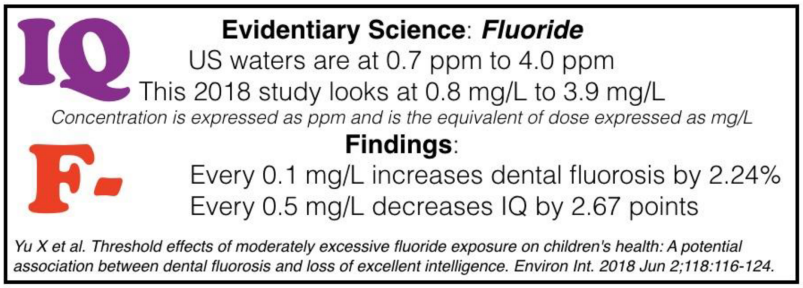
But again, let me draw you a picture drawn from one of the many studies used by the NTP.

My suggestions for addressing the "Oral Health Crisis" are as follows :

1. Take the $100 million HHS uses to promote fluoridation and untold millions communities spend on fluoridation schemes and spend it on dental clinics for preschoolers, low-income populations and the elderly.
2. Improve water infrastructure and the availability and affordability of nutrition food.
3. Make dental care part of health care, and make dentists accept it.

Sincerely,

Karen Favazza Spencer



Addendum Submission

"I would advise them (pregnant women) to drink bottled water or filtered water. . . ."

—Dimitri Christakis, M.D., MPH, editor in chief of *JAMA Pediatrics* on "Association Between Maternal Fluoride Exposure During Pregnancy and IQ Scores in Offspring in Canada" (August 19, 2019)

To Whom It May Concern:

Regarding Mr. Forte's testimony implying that the lack of fluoridation results in more cavities in children and others living in rural areas and Ms. Stabenow's and Dr. Farmer-Dixon emphasis on oral health for pregnant women and holistic care and "bad bacteria," allow me to offer the following:

The scientific of evidence is that fluoridation policy damages the biome and does not improve dental oral health in children or anyone else. Moreover, fluoridation policy contributes to "chronic illness" as fluoride is a drug that interferes with glucose metabolism, inhibits thyroid hormones, and promotes inflammatory diseases from allergies & arthritis to kidney disease & ulcerative colitis.

- Children living in communities with water sources containing less than 1 ppm fluoride concentration are still vulnerable to inflammatory, immunological, and other non-skeletal bodily harm. Dental fluorosis (DF) is present even at these low exposures and seems to be sex- mediated. DF a visible sign of fluoride poisoning while young *(https://www.sciencedirect.com/science/article/abs/pii/S0269749122022102).*
- Although there is no argument that fluoride exposure can result in dental and skeletal fluorosis, a structural defect, the impact on brains and bodies at current exposure levels is a source of controversy. The National Toxicology Program (NTP) reviewed the evidence of developmental neurotoxicity at concentrations considered optimal or safe by U.S. authorities. The NTP found that most studies suggested an adverse effect of fluoride exposure on children's IQ, starting at low levels of exposure *(https://pubmed.ncbi.nlm.nih.gov/36639015/).*
- Identifies fluoride as an environmental chemical that has adverse effects on articular cartilage and osteoarthritis (OA) risk. "In full sample analysis, a 1 mg/L increase in UF (urinary fluoride) level was associated with a 27% higher risk of OA" *(https://link.springer.com/article/10.1007/s12011-021-02937-2).*
- 18% of people drinking "optimally" fluoridated water in Canadian communities have a heightened risk of low thyroid function because fluoride interferes with iodine metabolism. Many of them will be sub-clinical and not know they are mildly hypothyroid, which nevertheless increases their risk for diabetes, high cholesterol, and other problems. Study excluded those already diagnosed with thyroid disease (CHMS) *(https://www.sciencedirect.com/science/article/pii/S016041201830833X).*
- This study found fluoride-induced insulin resistance and vitamin D deficiency lead to diabetes, and confirms fluoride exposure through drinking tap water with F-concentrations considered "safe" by US authorities is a risk factor for developing diabetes. The study demonstrate that vitamin D deficiency and fasting blood glucose levels (BGLs) are significantly associated with water fluoride lev-

els. The authors recommend using safe water (bottled or purified) and vitamin D supplementation *(https://pubmed.ncbi.nlm.nih.gov/36705502/)*.

Moreover, fluoridation doesn't prevent cavities or emergency dental care.

- On May 3, 2019, pediatric dentist Dr. Darren Riopelle of Grand Rapids, MI was featured in the local paper. He reported that many of his first time patients between 3 and 9 years old comes into his office with 3 to 20 cavities requiring full mouth restoration. Grand Rapids has been fluoridated since 1945.
- In 2014, Keys News in Florida reported that their district received an award for fifty years of fluoridation, and also that the local rotary club funded $10,000 worth of dental care for one little girl and extensive cosmetic dentistry for one little boy with "discolored teeth." Fluoridation results in discolored and brittle teeth disproportionately by race which is why many Civil Right leaders like Ambassador Andrew Young and Henry Rodriguez, director of the TX chapter of LULAC oppose fluoridation policy.

The dentists and doctors with the International Academy of Oral Medicine and Toxicology, International Academy of Biological Dentistry and Medicine, American Academy of Environmental Medicine and International College of Integrative Medicine are just a few of the professional scientific organizations with a patient focus who oppose fluoridation policy as harmful.

Finally, consider that only about 1% of the chemicals added to water supplies are consumed by man, the rest going to waste water. Moreover, fluoridation chemicals are contaminated with arsenic, aluminum, barium, cadium, etc. which are also consumed and go to wastewater. Environmental impact on salmon fisheries was one reason British Columbia ended fluoridation. I doubt Montana really wants to see the same ill effect in their back yards. Cessation did not increase cavities:

- A 2001 cessation study of six thousand children in British Columbia published in the *Journal of Community Dentistry and Oral Epidemiology* found that decay "decreased over time in the fluoridation-ended community while remaining unchanged in the fluoridated community," *http://www.NCBI.nlm.nih.gov/pubmed/11153562*.
- "Barium and aluminum levels approached those that the EPA found in samples of electroplating sludge, river sediment, and hazardous soils . . . contaminant content creates a regulatory blind spot that jeopardizes any safe use of fluoride additives." PJ Mullenix in "A new perspective on metals and other contaminants in fluoridation chemicals" (2014).

I do not disagree that oral health and affordable dental care aren't issues, they are. But I suggest you pay attention to science rather than magic potion mythology.

Sincerely,

Karen Favazza Spencer

More power to you if fluoridation doesn't bother you, but *not* the power to assume it's safe for your neighbor with kidney disease, his pregnant wife or their diabetic daughter!

Medical Hypotheses (2018): *https://www.sciencedirect.com/science/article/pii/S0306987718308600*

GreenMed (2019): *https://www.greenmedinfo.com/blog/wetoo-medical-assault-and-battery*

Gloucester Times (2022): *https://www.gloucestertimes.com/opinion/column-stop-poisoning-gloucester/article_0089c49c-1278-11ed-8a42-fb294218a4fe.html*

Message to CDC (2022): *https://www.youtube.com/watch?v=PzviupO1cDQ*

Annotated Bibliography (2015-2023): *https://www.fluoridelawsuit.com/science*

VIRGINIA HEALTH CATALYST
4200 Innslake Drive, Suite 202
Glen Allen, VA 23060
Phone 804–269–8720
https://vahealthcatalyst.org/

April 6, 2023

The Honorable Ron Wyden
U.S. Senate

221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
U.S. Senate
239 Dirksen Senate Office Building
Washington, DC 20510

Chairman Wyden and Ranking Member Crapo:

I am pleased to submit the following statement for the record on behalf of Virginia Health Catalyst regarding the Senate Finance Committee's Hearing, "An Oral Health Crisis: Identifying and Addressing Health Disparities." Thank you for the opportunity to submit a statement on this important issue.

Virginia Health Catalyst (Catalyst) is a public health nonprofit organization that ensures all Virginians have equitable access to comprehensive health care, including oral health. Catalyst meets this mission through advocacy and programmatic initiatives anchored by our four pillars: policy, public awareness, community and clinical care, and public health.

Please visit our website, *https://vahealthcatalyst.org* to learn more about how we create positive system changes through education, advocacy, and partnership.

General Comments

There is an oral health crisis in the United States:

- Dental disease is the most common chronic disease in children; it contributes to poor nutrition, failure to thrive, and other health problems.[1]
- Poor oral health is associated with cancer, cardiovascular disease, diabetes, and other physical and behavioral health diseases.[2, 3, 4]
- Only 63 percent of adults aged 18–64 had a dental visit in 2020.[5] Cost is the number one barrier to accessing care.[6]
- 76.5 million Americans do not have dental insurance, including 26.1 million Medicare enrollees, 8.5 million Medicaid enrollees, 16.1 million privately insured enrollees, and 19.6 million medically uninsured Americans.[7]

We urge Congress to take the following actions to alleviate this suffering:

1. Add a Comprehensive Dental Benefit to Medicare

Half of Medicare beneficiaries, and nearly three-fourths of Black Medicare beneficiaries, do not visit the dentist.[8] This lack of access directly affects beneficiaries' health, as roughly 15 percent of adults aged 65 and older have no natural teeth.[9]

Adding a comprehensive dental benefit to Medicare would dramatically expand seniors' access to oral health care. This proposal is also exceedingly popular. Roughly 90 percent of the public say that Congress should add dental, hearing, and vision benefits to Medicare.[10]

---

[1] "Improving Systems to Ensure Oral Health for All," *Oral Health for All 2020.*

[2] Zeng, Xian-Tao et al., "Periodontal Disease and Incident Lung Cancer Risk: A Meta-Analysis of Cohort Studies," *Journal of Periodontology,* Vol. 87, Issue 10, p. 1158–1164.

[3] Larvin, H., et al., "Risk of Incident Cardiovascular Disease in People with Periodontal Disease: A Systematic Review and Meta-Analysis," *Clinical and Experimental Dental Research,* Vol. 7, Issue 1, p. 109–122.

[4] Stöhr, J., et al., "Bidirectional Association Between Periodontal Disease and Diabetes Mellitus: A Systematic Review and Meta-Analysis of Cohort Studies," *Scientific Reports,* Vol. 11:13686.

[5] Cha, A., and Cohen, R., "Dental Care Utilization Among Adults Aged 18–64: United States, 2019 and 2020," Centers for Disease Control and Prevention, April 2022.

[6] "Consumer Survey of Barriers to and Facilitators of Access to Oral Health Services," Oral Health Workforce Research Center, 2019.

[7] "A Snapshot of the 76.5 Million Americans Without Dental Insurance," CareQuest Institute for Oral Health, 2021.

[8] Freed, M., and Neuman, T., "Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries," Kaiser Family Foundation, 2019.

[9] *Ibid.*

[10] "Two-Thirds of the Public Say the U.S. Should Play a Major Role in Distributing COVID–19 Vaccines Globally, but not Most Republicans," Kaiser Family Foundation, 2021.

2. Designate Adult Dental Services as a Mandatory Medicaid Benefit

Under current law, states have the option to include adult dental coverage in their Medicaid programs. Only half of these programs offer comprehensive dental benefits.[11]

Making adult dental services a mandatory Medicaid benefit would expand access to millions of Medicaid beneficiaries. Congresswoman Barragán (D–CA) has introduced legislation, the Medicaid Dental Benefit Act, that would require state Medicaid programs to provide comprehensive dental benefits to all beneficiaries. The benefit would cover routine diagnostic and preventive care, basic and major dental services, temporomandibular and orofacial pain disorder treatment, and other necessary services as defined by the U.S. Secretary of Health and Human Services.[12] We urge the Senate Finance Committee to consider this or similar legislation.

3. Recognize Adult Dental Services as an Essential Health Benefit

The Patient Protection and Affordable Care Act (ACA) significantly strengthened health care access and equity. However, one gap in the ACA is that it does not include adult dental care as an essential health benefit that qualified health plans are required to cover. This means that financial assistance for individuals and families cannot be used to cover adult dental benefits.

The ACA authorizes the Secretary of Health and Human Services to review and update the essential health benefits.[13] However, we urge Congress to amend the ACA to include adult oral health care as an essential health benefit. Doing so will send a clear message that oral health care is essential to overall health.

4. Fund CDC and HRSA Oral Health Grants for All States

The CDC State Actions to Improve Oral Health Outcomes grant funds 20 state programs to reduce dental caries, oral health disparities, and chronic diseases associated with poor oral health.[14] The current iteration of the grant funds 20 states an average of $370,000 per year for up to five years to support school sealant programs, support and increase access to community water fluoridation, and conduct oral health surveillance.[15]

We urge Congress to expand funding to provide grants to all 50 states. The CDC Division of Oral Health estimates it would need an additional $15 million yearly to do this. This small investment would have profound oral health benefits across the country.[16]

Similarly, the HRSA Grants to Support Oral Health Workforce Activities initiative helps states develop and maintain programs that address dental workforce needs in designated Dental Health Professional Shortage Areas (HPSA)s.[17] This important program funds 32 states for $3,200,000 per year. Expanding the program to all 50 states would cost little money but have a tremendous impact.

Conclusion

Oral health is essential to overall health. Congress should act now to recognize this fact and support better health for all Americans. Thank you again for the opportunity to provide this statement. Please do not hesitate to contact me at sholland@vahealthcatalyst.org or 804-269-8721 should you have any questions.

Sincerely,

Sarah Bedard Holland
Chief Executive Officer

[11] "State Medicaid Coverage of Dental Services for General Adult and Pregnant Populations," National Academy for State Health Policy, 2022.

[12] Press Release, "Barragán Introduces Medicaid Dental Benefit Act," July 19, 2021.

[13] Reusch, C., "The ACA Has Boosted Oral Health Access, Now Let's Keep the Progress Going," *Community Catalyst,* March 25, 2022.

[14] "CDC-Funded Programs," Centers for Disease Control and Prevention, 2019.

[15] CDC, 2019.

[16] "Congress has a Social and Fiscal Responsibility to Improve Oral Health for Everyone," Oral Health Progress and Equity Network, 2021.

[17] "Grants to States to Support Oral Health Workforce Activities," Rural Health Information Hub, 2021.