October 26, 2017

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
Attn: Strategic Plan Comments
200 Independence Avenue S.W.
Room 415F
Washington D.C. 20201

RE: Comments on the Draft Strategic Plan FY 2018-2022

Pursuant to a Request for Comments on the Draft Department Strategic Plan for FY 2018-2022, 82 Fed. Reg. 45032 (September 27, 2017), members of the Organized Dentistry Coalition (ODC) listed below are pleased to offer recommendations concerning issues addressed in the draft affecting the oral health of the American public.

Oral Health Issues Addressed in Draft

Concerning strategic goal 1: Reform, Strengthen, and Modernize the Nation's Health Care System

Issue: Under "Promote higher value and lower cost healthcare options" on page 8, lines 182-183, it states:

> *Promote the use of high-quality, lower cost healthcare providers, such as community health workers, dental therapists, and community organizations, where appropriate.*

Comment: The ODC recommends that the department include in its strategic plan Community Dental Health Coordinators (CDHCs), who are community health workers with dental skills, among the providers who represent a high-quality, lower cost healthcare option. This program trains individuals to directly address the underlying social determinants of health by providing patient navigation, oral health information, and preventive self-care for people who typically do not receive dental services for a variety of complex reasons --- poverty, geography, language, culture, diet, and a lack of understanding of why it is important to achieve and maintain a healthy mouth.

The role of a CDHC is threefold: educating the community about the importance of dental health and healthy behaviors; providing limited preventive services, such as fluoride varnish and dental sealants; and connecting the community to oral health teams that can provide more complex care. CDHCs work in inner cities, remote rural areas and Native American lands. Most grew up in these communities, allowing them, through cultural competence, to better understand the problems that limit access to dental care.

A 2016 article by the American Dental Association's (ADA) Health Policy Institute[1] on the participation of dentists in the Medicaid program addresses the barriers preventing low-income individuals from accessing dental services for reasons beyond just the participation of dentists. The article points out the need for more policy interventions that target patient behavior. CDHCs are specifically trained to address patient behavior and other barriers to accessing care. We believe that training CDHCs in greater numbers could dramatically improve oral health among people whose circumstances place them at greatest risk for untreated disease.

The ODC also requests that the department include in its strategic plan initiatives that reduce the number of people who visit the emergency room (ER) for a non-traumatic dental condition by referring them to dental practices or community health centers. Emergency room (ER) visits for non-traumatic dental problems cost more than providing regular care by oral health professionals. Also, most ER visits only provide patients with pain medication and antibiotics – but do not treat the underlying problem.

ER referral programs result in clear savings to the health care delivery system and, in particular, to government-funded programs, as the Medicare or Medicaid programs were the primary payer for almost half of ER dental visits in 2012 (43.2%).[2] In 2012, an ER visit for a dental condition happened every 15 seconds in the United States, costing taxpayers $1.6 billion. That came out to about $749 per visit.[3] Adults with private dental benefits, ages 18-64, spent in a year (2015 dollars) on average between $323 and $523. If we look at the same age range (19-64) and same utilization of services, the range in average spending per year for people that pay strictly out of pocket (i.e. cash patients, or perhaps uninsured patients) is $492 to $785.[4] The bottom line is that in most cases an individual can receive an entire year's worth of dental services for the price of a single visit to the ER for a dental emergency.

Currently, there are hundreds of ER referral programs in virtually every state in the United States.[5] There are a variety of referral models,[6] as many of these programs are the result of local interest in addressing an obvious need to reduce costs and provide comprehensive dental care. At least in part as a testament of how successful these programs have been is that more recent research indicates that the use of emergency rooms for dental conditions is decreasing.[7] Some

[1] Is the number of Medicaid providers *really* that important? Health Policy Perspective (March 2016), http://jada.ada.org/article/S0002-8177(16)00023-4/pdf, p. 223.

[2] Wall T, Vujicic M. Emergency department use for dental conditions continues to increase. Health Policy Institute Research Brief. American Dental Association. April 2015. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0415_2.ashx

[3] Wall T, Vujicic M. Emergency department use for dental conditions continues to increase. Health Policy Institute Research Brief. American Dental Association. April 2015. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0415_2.ashx.

[4] Yarbrough C, Vujicic M, Aravamudhan K, Blatz A. An analysis of dental spending among adults with private dental benefits. Health Policy Institute Research Brief. American Dental Association. May 2016. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0516_1.pdf

[5] http://www.ada.org/en/public-programs/action-for-dental-health/action-for-dental-health-map.

[6] 2017 ER Referral Program Models and Description, Action for Dental Health, ADA.

[7] Wall T, Vujicic M. Emergency department visits for dental conditions fell in 2013. Health Policy Institute Research Brief. American Dental Association. February 2016. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0216_1.ashx.

programs are reporting that use of the ER for dental pain patients has decreased 50-70 percent. The ODC believes that the use of community dental health coordinators (CDHCs) can continue this trend, connecting patients to dental homes and ensuring that timely care is delivered in the most appropriate, cost-effective venue possible.

Regarding the proposed promotion of dental therapists as a high-quality, lower cost health care provider, there is little empirical evidence (such as longitudinal clinical assessments of health outcomes) to support such a claim. The ODC knows of no study comparing any improvements in oral health among targeted populations to the potential outcomes had the same resources been directed to providing these patients with care from dentists. Concerning potential cost savings, existing dental therapist models in the United States are subsidized by sponsoring agencies and charge the same amount to payers as dentists. There are no savings for payers or patients and taxpayers are often shouldering an unnecessary burden. On the other hand, there are additional costs associated with setting up a new dental therapist program, requiring new curricula, a new accreditation process and a new system to test, license, and provide oversight. An assertion by proponents of dental therapists is that they will practice primarily in underserved and rural areas, but there is little evidence to substantiate that claim. In fact, seven years after the Minnesota program was created, there are 77 actively-licensed dental therapists in the state, only nine of which practice in a federally-designated rural area.[8]

Another common -- but incorrect -- assertion is that the dental workforce is aging and therefore declining in numbers, so there is a need for a new provider to help address the dental needs of a growing population. On the contrary, "the conventional wisdom that a looming retirement cliff will decrease the supply of dentists in the United States is not supported by the empirical evidence," according to Dr. Marko Vujicic, Chief Economist & Vice President of the ADA's Health Policy Institute (HPI).[9] In fact, the HPI model predicts the supply of practicing dentists will increase steadily through 2035, due largely to the growing volume of dental school graduates who will exceed the number of retirements from the profession.[10] Finally, it is important to understand that the current dental system has underutilized capacity, as nationally about 1 in 3 dentists say they are not busy enough,[11] so there is clearly no shortage of open chair time in many practices.

Issue: Under "Reduce disparities in access to health care" on page 16, lines 386 – 387, it states: *Support research to provide evidence on how to ensure access to affordable, physical, oral, vision, and behavioral, and mental health insurance coverage for children and adults.*

Comment: Ensuring access to affordable dental coverage for underserved children and adults is an extremely important component in reducing disparities in access to health care. The good news is that today more children have dental coverage than ever before in the United States. Between 2000 and 2012, the number of children without dental coverage decreased from 21.7

[8] Minnesota Board of Dentistry, August 2017
[9] Vujicic, M. The "de-aging" of the dentist workforce. Health Policy Perspectives. JADA. 2016; 147(10): 843-845.
[10] Ibid.
[11] Vujicic, M. Solving dentistry's "busyness" problem. Health Policy Perspectives. JADA. 2015; 146(8): 641-643.

percent to 13.1 percent.[12] According to the ADA's Health Policy Institute, Medicaid expansion has improved access to dental care for low-income adults, allowing over 5 million adults to gain dental coverage. This has led to a decline in cost barriers to dental care for low-income adults and a modest increase in dental care utilization. Expanded dependent coverage has also improved access to dental care for young adults. Although dental care was not subject to the expanded dependent coverage provision of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148; 111-152), dental insurance coverage for young adults expanded anyway through a "spillover" effect. This reduced financial barriers to dental care and increased dental care utilization for this age group.

Looking forward, the ODC believes it is vitally important, at a minimum, to retain the gains in coverage provided by the ACA. This requires the federal government to provide steadfast support for the ACA provisions offering subsidies to help low income individuals purchase coverage and for the expanded Medicaid program. There is also a good deal that should be done at the federal level to provide states guidance on reducing administrative barriers to providing care to Medicaid beneficiaries. "Medicaid reform" is one of the ADA's Action for Dental Health initiatives. More detail may be found at http://www.ada.org/en/advocacy/advocacy-issues/medicaid.

Issue: Under "Reduce disparities in access to health care" on page 16, lines 388 – 391, it states: *Identify individuals and populations at risk for limited health care access and assist them to access health services, including prevention, screening, linkages to care, clinical treatment, and relevant support services, including through mobilization of faith-based and community organizations.*

Comment: As stated in detail above, the ODC very strongly recommends the department include Community Dental Health Coordinators in its strategic plan as proven community health workers with needed dental skills who are specifically trained to identify individuals and communities at risk and to help those individuals and communities "connect the dots" within the cumbersome health care delivery system. CDHCs are the health care providers who can best help at risk individuals find the dental health care professionals they need in a timely fashion and offer cost-effective preventive and educational services that are delivered in a community-friendly manner.

In addition, the ODC compliments the department on its continued efforts to emphasize the importance of oral health during pregnancy. We recommend that these efforts be explicitly mentioned in this new strategic plan, such that all pregnant women receive instruction on oral hygiene care for themselves and their children, which emphasizes the importance of seeking timely and regular preventive dental services and includes information on how to access those services, especially for those women who qualify for government assistance programs.

[12] Medical Expenditure Panel Survey, AHRQ.

Issue: Under "Reduce provider shortages in underserved and rural communities" on page 17, lines 416-419, it states:

> *Improve access to behavioral and oral health services in underserved and rural communities by supporting the training, recruitment, placement, and retention of behavioral health, dental health, and primary care providers to address workforce shortages, reduce disparities and ensure an equitable workforce distribution.*

Comment: The ODC supports increased funding for the National Health Service Corps, the oral health division in the Indian Health Service, the oral health division of the Centers for Disease Control and Prevention, and Title VII General and Pediatric Residencies and the Dental Health Improvement Act within the Health Resources and Services Administration (HRSA). ODC members have also long supported a variety of other HRSA programs that improve training, recruitment and/or placement of health care professionals in underserved and rural communities, such as the Health Careers Opportunity Program, Area Health Education Centers, and Maternal and Child Health – SPRANS.

Issue: Under "Collect, analyze, and apply data to better understand opportunities to strengthen the healthcare workforce" on page 18, lines 442-444, it states:

> *Examine state and tribal models that have allowed providers – such as midwives, nurse practitioners, and dental health therapists – to practice or provide care outside of a physician's or dentist's practice.*

Comment: In summary, as stated above:

- there are no studies comparing any improvements in oral health among targeted populations to the potential outcomes had the same resources been directed to providing these patients with care from dentists;
- dental therapist programs in the United States have not proved sustainable without significant ongoing supplemental government or outside organizational spending;
- there are no cost savings to private or public sector payers or to patients (e.g. Medicaid reimbursement rates are the same for a given procedure regardless of who provides the service);
- there are additional training and potential licensing costs to the healthcare system;
- adding dental therapists to a state's provider mix does not necessarily result in more services for underserved and rural populations, as many therapists locate in urban areas; and
- there is no need for such a provider, as there are many more dentists coming into the profession and many current practitioners have open chair time.

There is, however, an access to oral health care problem for underserved and rural populations due to the *distribution* of dentists. Much more needs to done to provide incentives (e.g. National Health Service Corps (NHSC) loan repayments, tax credits for serving in underserved areas, etc.) and more needs to be done to improve the Medicaid program to enhance access. The economic and geographic barriers affect *all* providers who seek to provide care to underserved populations and in rural settings.

The dental therapist model is a “one size fits all” approach that misses the mark. Multiple barriers keep people from getting the dental care they need, including poverty, geography, lack of oral health education, language or cultural barriers, fear of dental care, and the belief that people who are not in pain do not need dental care. Expanding the Action for Dental Initiatives (e.g. CDHCs, ER referrals, community water fluoridation) detailed below will make a real difference because it is multifaceted and places the emphasis on prevention.

Oral health and overall health are connected. Many patients who lack access to oral health care suffer from other health problems, such as diabetes, obesity, tobacco use, or excessive alcohol consumption that can complicate the provision of dental care. As doctors of oral health, dentists are uniquely qualified to identify these “comorbidities” and properly calibrate treatment plans. The ODC members listed below oppose allowing non-dentists (including dental therapists) to perform surgical dental procedures, such as “simple” extractions, restorations and pulpotomies as there can be unanticipated complications in any of these procedures, especially if the patient has one or more of the health problems cited above.

For all of these reasons, we believe there is no need to promote a new provider who performs some, but not all, of the functions of a licensed dentist. The emphasis should be on directly addressing the many barriers to accessing dental care with a shift away from a model of “drilling, filling and extracting” to one of disease prevention.

Sincerely,

American Dental Association
Academy of General Dentistry
American Association of Endodontists
American Academy of Oral and Maxillofacial Pathology
American Academy of Pediatric Dentistry
American Association of Oral and Maxillofacial Surgeons
American Association of Orthodontists
American College of Prosthodontists