AAPD 2012 LEGISLATIVE FACT SHEET

HRSA TITLE VII PEDIATRIC DENTISTRY APPROPRIATIONS

REQUEST: *Provide FY 2013 funding of $32 million for the HRSA Title VII Primary Care Dental Training Cluster and related oral health programs, with not less than $8 million going towards Pediatric Dentistry Training programs. This represents funding at the FY 2012 level and is consistent with the Administration's FY 2013 budget request.*

BACKGROUND: Pediatric Dentistry training is critical to meeting the nation's oral health care needs. The two to three year Pediatric Dentistry residency program[1], taken after graduation from dental school, immerses the dentist in scientific study enhanced with clinical experience. This training is the dental counterpart to general pediatrics. The trainee learns advanced diagnostic and surgical procedures, along with:

- child psychology and behavior guidance
- oral pathology
- pharmacology related to the child
- radiology
- child development
- management of oral-facial trauma
- caring for patients with special health care needs
- sedation and general anesthesia.

Since children's oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists. Healthy children, as well as hospitalized and chronically ill children or children with disabilities, often benefit from a team approach. Access to dentists is critical for Medicaid and CHIP populations. By the nature of their training, pediatric dentists are able to provide comprehensive oral health care to children. **Pediatric dentists treat a higher percentage of Medicaid and CHIP patients in their practices than any other type of dentist, and are especially successful with this population because of their advanced clinical training and expertise in behavior guidance.** All pediatric and many general dentists treat children, but pediatric dentists train 100 percent of all the dentists who treat children. Pediatric dentists are the backbone of the pediatric oral health care delivery system. Pediatric dentists are extremely efficient in fulfilling the goal of ensuring all children have access to high quality comprehensive dental services, as they spend 92 percent of their time treating patients – 20 percent of whom are enrolled in public insurance programs such as Medicaid or CHIP. On average, **70 percent** of pediatric dentists participate in Medicaid. With on average 4,395 patient visits per year per dentist, they provide in aggregate approximately 4.66 million Medicaid dental visits per year. Pediatric dentists also have a positive local economic impact; offices employ 2 to 3 dental assistants per doctor, with 45 percent of offices employing 3 or more dentists.

The authority to fund Pediatric Dentistry residency training under Title VII was first enacted under the Health Professions Education Partnerships Act of 1998. This expanded the existing General Dentistry training authority, providing three-year "start up" funds to either increase Pediatric Dentistry positions at existing programs or initiate new programs. **In the first decade-plus of funding, over $50 million was allocated to over 60 Pediatric Dentistry programs, including 10 new programs.** Every program that can be funded is critical, as Pediatric Dentistry residency programs provide a significant amount of care to underserved populations. **Two-thirds of the patients treated in these programs are Medicaid recipients.** Mentally or physically disabled persons are also treated through these programs.

JUSTIFICATION: There is a clear shortage of pediatric dentists, as the U.S. is not training enough pediatric dentists to meet the increasing need for pediatric oral health care services. Training slots have not kept pace with demand. **43 percent of all applicants to Pediatric Dentistry training positions for 2012–13 were turned away due to a lack of positions.** Some training programs have 25 times the number of applicants than can be accommodated.

Because of increased attention to this problem – and **primarily as a result of Congressional support for increased funding of Title VII** – almost 200 new first-year positions have been created. Still, many positions for pediatric dentists remain open in private practice, public health clinics, dental schools, residency training programs, corporate employment, and government service. The funding requested in Fiscal Year 2013 will go a long way in the process of filling these crucial positions and strengthening the faculty workforce.

Pediatric Dentistry Title VII grantees are meeting stated federal goals. A 2008 article, "The Impact of Title VII on General and Pediatric Dental Education and Training," presented a comprehensive review of the impact of the Title VII program on general and pediatric dental training, as part of an entire issue of the journal Academic Medicine (November 2008, Volume 83, Issue 11) devoted to Title VII issues. The main conclusion was that the program has been important in the growth and expansion of residency training in pediatric and general dentistry, by facilitating a more diversified dental workforce and providing outreach and service to underserved and vulnerable populations. Furthermore, "As the need for more pediatric dentists and general dentists with advanced training is expected to continue, Title VII's role in expanding workforce capacity, and in supporting [general dentistry and pediatric dentistry] curricula, will remain important in the foreseeable future."

Under the Affordable Care Act (ACA), Title VII authority was expanded to create a primary care dental funding cluster. Authority was broadened to allow use of funds for faculty development, predoctoral training, and **faculty loan repayment**. The latter initiative has long been advocated by the AAPD, on account of the significant difficulties in recruiting qualified individuals to fill currently vacant faculty positions. This is especially acute in pediatric dentistry. A critical factor in recruiting and retaining dental

[1] *Three year programs generally require additional masters' level research and often prepare trainees for careers in academic dentistry.*

school faculty from recent dental school or residency program graduates is the staggering student loan debt and income disparity with private practice. The average graduating dental student loan debt was $200,000 in 2010, and academic positions typically pay only one-third of what graduates can earn upon entering private practice.

Thanks to strong support from Congress, FY 2010 funding allowed for the first new grants since FY 2007, including the first-ever pediatric dentist faculty loan repayment awards. Programs may support loan repayment contracts of up to $250,000 in aggregate over five years to recruit and retain faculty. Full-time faculty members would be eligible for repayment of 10, 15, 20, 25, and 30 percent of their student loan balance (principal and interest) for each year of service with the pediatric or general dentistry program. Funding provided by Congress in FY 2011 and 2012 allowed for continuation of all grants first awarded in FY 2010, which are on a five year cycle, as well as a new grant cycle for Faculty Development in FY 2012. See charts below on selected FY 2010 pediatric dentistry grantees:

Title VII Dental Faculty Loan Repayment Grantees FYs 2010-14

Program	State
Medical College of Georgia	GA
University of Mississippi	MI
Lutheran Medical Center (NY- *this is a large multi-site program with 24 pediatric dental residents; funds are expected to assist several faculty members in both pediatric and general dentistry).*	NY
University of Nevada, Las Vegas (UNLV)	NV
University of Washington	WA

The UNLV program is an excellent example of the effectiveness of this new initiative according to Dean Karen P. West:

> "We have been delighted to have [Dr. Cody Hughes] return to UNLV as a faculty member. It was an honor for the school to be able to hire one of its premier graduates. This grant will give us the ability to retain an emerging leader in pediatric education which Dr. Hughes is quickly becoming." Dr. Hughes' program director, Dr. Jeanne Hibler, observes: "Recruitment of qualified young faculty, like Cody, allows an institution to shape and train the practitioner as a professional educator while allowing clinical experience and expertise to develop. Without a loan repayment program, it is financially difficult for recent graduates and specialists to maintain a career as an educator in dentistry."

The **University of Washington (UW)** was able to assist Dr. Travis Nelson, the son of a pediatric dentist, who saw firsthand that "in spite of the thousands of teeth he had fixed over the years, the problem of childhood dental caries was only getting worse. That realization influenced me to pursue a career in which I could have an impact in the way we manage this disease and train the clinicians of the future." Dr. Nelson accepted the position of Acting Assistant Professor at UW School of Dentistry, starting in October 2010. In this role he serves as supervising attending dentist for the resident clinics, and is responsible for treating patients in faculty practice and operating room environments. While Dr. Nelson was in the residency program, Dr. Joel Berg, Chair, and AAPD President-elect, recognized his passion and strongly desired to retain Dr. Nelson as part of the UW faculty:

> "The Title VII award represents a real "win-win" for the UW Department of Pediatric Dentistry. Like many recent graduates, Dr. Nelson has significant educational debt – and like many programs of its kind, UW faces a huge obstacle in the recruitment and retention of new faculty. The large reduction in salary earned in academia as opposed to private practice deters many new dentists."

Title VII Postdoctoral Pediatric Dentistry Grantees FYs 2010-14

Program	State
UCLA	CA
University of Southern California	CA
University of Connecticut	CT
Yale – New Haven	CT
Howard University	DC
Miami Children's	FL
Nova Southeastern University (new program for children with autism)	FL
Children's Hospital, Boston	MA
Tufts University	MA
University of Nebraska	NE
Columbia University	NY
Lutheran Medical Center	NY
Montefiore Medical Center (the grant will benefit both the General and Pediatric Dentistry residency programs)	NY
University of Puerto Rico	PR

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AAPD 2012 LEGISLATIVE FACT SHEET

DEFINING THE PEDIATRIC ORAL HEALTH BENEFIT IN THE ESSENTIAL HEALTH BENEFITS PACKAGE UNDER THE AFFORDABLE CARE ACT (ACA)

REQUEST: *Since the Consumer Information and Insurance Oversight (CCIIO) agency's bulletin of Dec. 16, 2011, and follow-up CMS FAQ of Feb. 17, 2012, on essential health benefits still leave many questions concerning the exact scope of pediatric oral health benefits to be offered in state health insurance exchanges, Congress should ensure that federal oversight promotes adoption of benchmark coverage consistent with the AAPD's model dental benefits policy. This will help all children have access to necessary diagnostic, preventive, and restorative services to assure optimal oral health function, which is the most important benefit of establishing a dental home[1] for every child by age one.*

BACKGROUND: The Affordable Care Act (ACA) requires that all insurance issuers in the individual or small group markets – inside or outside of state insurance exchanges – must cover "essential health benefits," including pediatric oral care. This must be "equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary." Under the ACA's directive, the Secretary of Labor conducted survey of employer-sponsored coverage to determine the benefits typically covered. The Dept. of Labor report of April 15, 2011, included the following discussion of pediatric oral health coverage:

> " . . . Plans typically grouped dental services into categories, such as preventive services (typically exams and cleanings), basic services (typically fillings, dental surgery, periodontal care, and endodontic care), major services (typically crowns and prosthetics), and orthodontia. Cost sharing for dental services typically involved an annual deductible – the median was $50 per person. After meeting the deductible, dental plans often paid a percent of covered services up to a maximum annual benefit. The median percent paid by the plan was 100 percent for preventive services, 80 percent for basic services, and 50 percent for major services and orthodontia. The median annual maximum was $1,500; a separate maximum applicable to orthodontic services also had a median value of $1,500."

The Dec. 16, 2011, CCIIO Bulletin indicated that states will be permitted to selected benchmark plans, defined as: the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; any of the largest three state employee health benefit plans by enrollment; any of the largest three national Federal Employee Health Benefit Plan (FEHBP) options by enrollment; or the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state. **If the pediatric oral health benefit is missing from the chosen benchmark plan, a state must supplement the benchmark to cover the EHB category with one of the following options: the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or the state's separate Children's Health Insurance Program (CHIP).** This was confirmed in a FAQ document issued by the CMS Center for Medicaid and CHIP Services on Feb. 17, 2012.

During the transitional years of 2014-2015, if a state chooses a benchmark plan that is subject to existing state benefit mandates, those mandates would be included in the EHB package, obviating the requirement that the state defray the cost of the mandates. If the state selects a benchmark that does not include some or all of the mandates, the state would have to pay for those mandates not covered by the benchmark. For 2016 and beyond, the agency will develop an approach that might exclude some state benefit mandates from the EHB package.

The AAPD, the American Dental Association, and other members of the Organized Dentistry Coalition (ODC) commented to CCIIO on Jan. 31, 2012 that the benchmark plans identified fall short of finding the proper balance between affordability and ensuring a comprehensive set of pediatric oral health benefits for the EHB package. The potential for the selection of an inadequate dental benefit embedded in a benchmark plan is simply too great. ODC urged HHS to address the pediatric oral health benefit in a separate guidance. ODC suggested the following general table be used as a guide for determining if the benchmark plan chosen by the state is in line with the typical employer-sponsored plan currently offered in the dental benefits market.

- *Preventive and Diagnostic Services* – 100 percent coverage
- *Basic Restorative Services* – 80 percent coverage
- *Major Restorative Services* – 50 percent coverage
- *Orthodontics* – 100 percent coverage for medically necessary treatment, including cleft palate and other similar craniofacial anomalies

ODC also referenced the American Academy of Pediatric Dentistry's Model Dental Benefits Policy. This policy delineates the diagnostic, preventive and restorative services that are essential for the pediatric population. (see more details on back).

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

ODC also recommended that a final guidance or proposed regulations address the need to ensure proper coordination between the coverage provided by medical and dental plans to avoid coverage denials by both plans that result in children with congenital craniofacial anomalies and other medical conditions "falling through the cracks." This includes a requirement that benchmark plans include state requirements for general anesthesia for dental services in 2016 and beyond.

JUSTIFICATION: This recommendation addresses a major barrier to oral health care access to children by promoting robust dental insurance coverage for currently uninsured children. It is intended to address unmet oral health care for many children. A study published in the 2011 *American Journal of Public Health*, utilizing data from the 2008 North Carolina Health Assessment and Monitoring Program, concluded that children with poorer oral health status were more likely to experience dental pain, miss school, and perform poorly in school. A study published in the Jan. 2012 *Journal of the American Dental Association* found that that the number of young children with early childhood caries who sought treatment at emergency departments and ambulatory surgery facilities in New York state rose sharply between 2004 and 2008. This reflects similar finding in California and Texas.

As provided in the AAPD's **Policy on Model Dental Benefits for Infants, Children, Adolescents, and Individuals With Special Health Care Needs**, available at: *http://www.aapd.org/media/Policies_Guidelines/P_ModelDentalBenefits.pdf*, an essential pediatric oral health benefits package should consist of the following (see policy for complete details):

A. Preventive services.

B. Diagnostic procedures.

C. Restorative and endodontic services to relieve pain, resolve infection, restore teeth, and maintain dental function and oral health.

D. Orthodontic services including space maintenance and services to diagnose, prevent, intercept, and treat malocclusions, including management of children with cleft lip or palate and/or congenital or developmental defects.

E. Dental and oral surgery which shall include sedation/general anesthesia and related medical services that shall be furnished on an inpatient basis when medically necessary.

F. Periodontal services to resolve gingivitis, periodontitis, and other periodontal diseases or conditions in children.

G. Prosthodontic services, including implants to restore oral function.

H. Diagnostic and therapeutic services related to the management of orofacial trauma.

I. Drug prescription for preventive services, relief of pain, or treatment of infection.

J. Medically necessary services for preventive and therapeutic care in patients with medical, physical, or behavioral conditions. These services include, but are not limited to, the care of hospitalized patients, sedation, and general anesthesia in outpatient or inpatient hospital facilities.

K. Behavior guidance services necessary for the provision of optimal therapeutic and preventive oral care to patients with medical, physical, or behavioral conditions. These services may include both pharmacologic and non-pharmacologic management techniques.

L. Consultative services provided by a pediatric dentist when the dental home has been established with a general practitioner or when requested by another dental specialist or medical care provider.

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