Julie Stitzel
Director, Pew Children's Dental Campaign
The Pew Charitable Trusts

Statement before the Joint Committee on Public Health

September 29, 2015

Chairwoman Hogan, Chairman Lewis and Members of the Committee, thank you for holding this hearing and for the opportunity to testify. My name is Julie Stitzel, and I am the director of the Pew Charitable Trusts' children's dental campaign. I am pleased to appear before you today to provide national and Massachusetts specific data on oral health access and to support S. 1118/ H. 249 sponsored by Sen. Chandler and Representative Pignatelli—an evidence-based policy proven to increase access to care in a financially sustainable way. The Pew Children's Dental Campaign works to improve children's dental health by advocating for more prevention, adequate funding for care, and ensuring there is a sufficient workforce to care for low-income children.

Access to dental care in the United States

Dental care is the greatest unmet health need among children in the United States[1]—and dental disease is five times more common than asthma.[2] Every year, tens of millions of children, disproportionately low income, go without seeing a dentist in our country. In 22 states, less than half of Medicaid-enrolled children received dental care in 2013.[3] In 2014, the U.S. Department of Health and Human Services reported that roughly 47 million Americans live in "dental health professional shortage areas"—regions that have a scarcity of dentists relative to the population. In six states, at least 20 percent of the population has little or no access to dentists.

Unlike the medical team, which includes a variety of practitioners, the current dental workforce is limited to dentists, dental hygienists, and dental assistants. More than a dozen states are considering authorizing dental professionals, similar to physician assistants on a medical team, who would expand the reach of the dental team to those who need care most. These providers, who cost roughly a third of the cost to train as training dentists, have the opportunity to bring care closer to patients in places like schools, assisted living centers, mobile dental clinics and community health centers.[4] They can even work in existing dental offices to help dentists serve more low-income patients.

Lack of access to dental care leads to more and more people entering hospital emergency rooms (ERs) for preventable dental conditions. These ER admissions impose a significant and unnecessary burden on state budgets. According to the American Dental Association's Health Policy Resources Center, the number of dental ER visits in the U.S. increased from 1.1 million in 2000 to 2.18 million in 2012.[5] Emergency room visits to treat dental conditions cost the health care system $1.6 billion in just 2012.[6]

Furthermore, hospitals are generally unable to treat conditions such as dental abscesses and toothaches, as few ERs have dentists on staff or clinicians who have the training to treat the root causes. Sadly, the ER visit typically results in the patient receiving a prescription for pain

killers, antibiotics, and a referral to a dentist. Some patients who leave without the underlying dental problem addressed return to the ER later as their condition deteriorates, for care costing far more than services provided in a dental office or clinic.

It is the wrong care, at the wrong time, in the wrong setting and it is costing Massachusetts taxpayers.

Access to dental care in Massachusetts

In Massachusetts, the burden of dental disease is disproportionately borne by low-income residents, racial and ethnic minorities, people with disabilities, seniors in long-term care, and those living in rural areas and inner cities. Many in these groups struggle to access dental care, often because they cannot find a dentist who accepts public insurance, are unable to get to a dental office because of mobility challenges, or cannot afford a dentist.

In 2014, 47 percent of young people ages 1 to 21 (more than 290,000 individuals) who were enrolled in MassHealth did not see a dentist.[7] Most dentists in Massachusetts do not accept Medicaid.[8] In fiscal year 2013, only 21 percent of dentists licensed in the state billed more than $10,000 to MassHealth.[9] The statistics for adults in Massachusetts are worse. 47 percent of adults with special needs had untreated tooth decay in 2010.[10]In 2009 (which is the most recent data available), 59 percent of Massachusetts seniors (age 60-plus) in long-term-care facilities had untreated decay.[11] As of 2014, Massachusetts had 61 federally designated dentist shortage areas with half a million people living in those areas.[12]

Although Massachusetts has made great progress in expanding health insurance coverage among its residents and increasing the availability of primary health care,[13] the state has not had the same success in expanding access to dental care. Simply, coverage does not equal access. These gaps in access have high and growing costs. When people cannot obtain dental care, they sometimes visit emergency rooms for relief; the state's Medicaid program, MassHealth, paid $11.6 million from 2008 to 2011 for emergency room dental care for adults.[14] However, because ERs are not equipped to treat dental problems and usually only provide prescriptions for antibiotics and painkillers, a patient still requires a dentist to treat the underlying problem.

The dental delivery system is currently failing the vulnerable populations of Massachusetts who need care the most (low-income children, low-income adults, the elderly and adults with special needs) and it has a direct financial impact on the state. A proven way to address this problem is by authorizing dental midlevel providers—who can deliver cost-effective dental care to those who most need it, especially in settings beyond the traditional dental office.

Dental hygiene practitioners: Proven and Effective

S. 1118/H. 249 would authorize a dental midlevel professional called a dental hygiene practitioner (DHP) in Massachusetts. While these practitioners have been practicing in the United States for more than a decade, they have been increasing access to dental care for vulnerable populations in more than 50 countries around the world for nearly a century.

DHPs are dental hygienists who complete additional training in order to deliver routine but critically necessary care— such as filling cavities, placing temporary crowns, and extracting teeth. They work under the general supervision of a dentist, using telehealth technology to share X-rays and patient records with the dentist and consult on complicated cases. This system enables them to bring care directly to people in schools, nursing homes, and other community settings.

In August of this year, the Commission on Dental Accreditation (CODA) overwhelming voted to implement dental therapy education standards—a significant milestone for the profession. After more than three years of deliberation and a review of thousands of pages of research and data evaluating dental midlevel providers, CODA—who is comprised of 30 members representing the American Dental Association, the American Dental Education Association, the American Dental Hygienists' Association among others—answered three fundamental questions. Are they safe? Yes. Do they have the ability to increase access to care to the public? Yes. Is the demand for this provider in the field substantial enough to create nationalized accreditation standards? Yes. According to CODA, there is "evidence of need and support from the public and professional communities to sustain" dental therapy education programs and "there is a body of established, substantive, scientific dental knowledge" that underpins the discipline. While there is some opposition among dental trade organizations for DHPs, there should be no doubt that the evidence supporting the safety and efficacy of these providers is strong.

The DHP-like practitioners working in other states (Alaska and Minnesota) are clearly fulfilling their expected role to extend the reach of the dental team to populations currently left out of the system. A joint report released last year by the Minnesota Board of Dentistry and Department of Health evaluating the impact of DHP-like providers concluded that they are increasing access to care for vulnerable populations and increasing the efficiency of clinics and dental offices. Further, patients and supervising dentists were more than satisfied with the care they delivered, and there is a growing demand to hire these providers. Finally the report indicated that they have the potential to decrease ER utilization for dental related issues.

Moreover, they enable the dentist-led team to reach underserved people in a financially sustainable way. A case study released by Pew last year found that two dental midlevel providers generated more than $216,000 in estimated net revenue after accounting for employment costs, including full-time dental assistants.[15] Savings from the lower costs of these practitioners have allowed Minnesota dental practices to treat more Medicaid-insured and uninsured patients.[16] One private practice that employs a DPH-like practitioner made an additional $24,000 in profit and served 500 more Medicaid patients in the DPH's first year, even though the state has the lowest pediatric dental reimbursement rate (27 % of commercial fees) in the country.[17] Massachusetts' pediatric reimbursement rate is 58%, the 10th highest in the country, suggesting that these numbers have the potential to be much higher for a DPH practicing in your state.

Pew commends this Committee's commitment to oral health and dedication to seeking evidence-based policy solutions that increase access to dental care in Massachusetts. Pew supports S. 1118/ H. 249 because dental hygiene practitioners are tested, proven, and effective and we urge a favorable report from this committee.

[1] Newacheck, P. W., Hughes, D. C., Hung, Y. Y., Wong, S., & Stoddard, J. J. (2000). The unmet health needs of America's children. Pediatrics, 105(4 Pt 2), 989–997.

[2] 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.

[3] This figure counts children age 1 to 18 eligible for the Early and Periodic Screening, Diagnostic and Treatment Benefit. See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Annual EPSDT Participation Report, Form CMS-416 (State) Fiscal Year: 2011, April 1, 2013. Analysis by The Pew Charitable Trusts.

[4] Compares cost of training a Master's level advanced dental therapist at the University of Minnesota to four times the average cost of first year dental school tuition. The Pew Charitable Trusts. Growing the Dental Workforce: The Critical Role of Community Colleges and Workforce Investment Boards. November 2013. http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2013/pewdentalworkforcepdf.pdf.; American Dental Education Association. Average U.S. Dental School Tuition and Fees for Resident and Nonresident First-Year Students, 2000-01 Through 2013-14 (Current Dollars), http://www.adea.org/data/seniors/.

[5] American Dental Association. Emergency Department Use for Dental Conditions Continues to Increase. April 2015; American Dental Association. Dental-Related Emergency Department Visits on the Increase in the United States. May 2013.

[6] American Dental Association. Emergency Department Use for Dental Conditions Continues to Increase. April 2015

[7] U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services, Annual EPSDT Participation Report, Form CMS-416 (State) Fiscal Year: 2014. Accessed July 29, 2015 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html. Utilization calculated as percent of total individuals eligible for EPSDT age 1-21 who received any dental service.

[8] Massachusetts Department of Public Health. Health Professions Data Series, Dentist 2012. November 2014. http://goo.gl/JXGFPz

[9] Massachusetts Health Council, Common Health for the Commonwealth: Massachusetts Report on the Preventable Determinants of Health—8th Edition (2014),http://c.ymcdn.com/sites/www.mahealthcouncil.org/resource/resmgr/Docs/2014-HSIR.pdf

[10] Massachusetts Health Council. Common Health for the Commonwealth: Massachusetts Reports on the Preventable Determinants of Health. 2012.

[11] Massachusetts Department of Public Health, Office of Oral Health. The Commonwealth's High-Risk Senior Population: Results and Recommendations from a 2009 Statewide Oral Health Assessment. Boston, Massachusetts. July 2010.

[12] U.S. Department of Health and Human Services, Health Resources and Services Administration. Designated Health Professional Shortage Area Statistics. As of November 10, 2014.

[13] Kaiser Family Foundation, Massachusetts Health Care Reform: Six Years Later, (May 2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf.

[14] Massachusetts Center for Health Information and Analysis. Massachusetts' Emergency Departments and Preventable Adult Oral Health Conditions: Utilization, Impact and Missed Opportunities (2008-2011). December 2012

[15] The Pew Charitable Trusts, Expanding the Dental Team: Increasing Access to Care in Public Settings (June 2014), http://www.pewtrusts.org/~/media/Assets/2014/06/27/Expanding_Dental_Case_Studies_Report.pdf

[16] Minnesota Department of Health and Minnesota Board of Dentistry. Early Impacts of Dental Therapists in Minnesota: Report to the Legislature 2014. February 2014.

[17] Nasseh K, Vujicic M, Yarbrough C. A ten-year, state-by-state, analysis of Medicaid fee-for-service reimbursement rates for dental care services. Health Policy Institute Research Brief. American Dental Association. October 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_3.ashx.