

Surveying the Federal Dental Infrastructure

What does the term “oral health safety net” mean? Generally, it refers to the entire delivery system designed to bring dental care to those populations who don’t have it, or who have it only sporadically. It refers to all dental professionals who deliver that care, as well as the facilities where it is delivered. It refers to private and public funding sources, as well as research activities that translate to better and more efficient care.

There are many elements to federal dental infrastructure. To follow are the main components of the federal system.

Medicaid, covering about 68 million people, is administered by the Center for Medicare and Medicaid Services (CMS) and represents a significant part of the oral health safety net, at least for children, for whom participating states must provide dental services in compliance with federal law. States may elect to provide dental services to their adult Medicaid-eligible population. However, although most states provide at least emergency dental services for adults, only a few of them provide comprehensive dental care. There are no minimum requirements for adult dental coverage. The ADA has long sought to redress this omission. The association withheld support for President Obama’s health care reform legislation last year in part because of its failure to extend Medicaid coverage to adults.

Reimbursement rates for Medicaid dental services vary widely, with some states paying so little that dentist participation is low and access to care is therefore limited. The program in most states also suffers from chronic, burdensome red tape that inhibits both participation and utilization.

Already reeling from cuts by states seeking to balance their budgets, Medicaid programs now face an even greater fiscal disaster. Assistance that state Medicaid budget received under the American Recovery and Reinvestment Act (\$137 billion over the past three years) is going to end this month as those funds dry up. What has not dried up, however, is the requirement under the Patient Protection and Affordable Care Act (ACA) that state Medicaid programs maintain eligibility standards that were in effect when the president signed the law in March 2010.

While the states might consider reducing reimbursement to providers as a way to address budget shortcomings, Medicaid officials must be mindful of a proposed rule by the Centers for Medicare and Medicaid Services that would require states to publicize their programs’ adequacy. The proposal reaffirms and helps reinforce existing federal law that says Medicaid provider payment rates must be set at levels sufficient to assure enrollees have the same access to health care services as people with other types of health insurance.

States are beginning to find themselves in extremely difficult situations as their options for addressing Medicaid shortages narrow. The ADA is working with its state constituent societies to protect dental programs as states attempt to fix their Medicaid problems.

The State Children’s Health Insurance Program (CHIP) provides health (including oral health) coverage to uninsured, low-income children in families with annual income above the Medicaid eligibility thresholds and covers about 7.7 million people. It is a huge program whose enrolled populations differ nationwide, depending on how officials in the states determine eligibility. Some states simply use the CHIP money to extend eligibility in Medicaid.

Other HHS agencies provide grants to assist state and local governments in oral health programs. The **Centers for Disease Control and Prevention (CDC)** funds and promotes community water fluoridation. CDC, through its Division of Oral Health (DOH), also conducts research on the nation’s oral health status and works closely with state health and dental associations on promoting oral disease prevention. The ADA opposes a recent proposal by CDC

officials to downgrade DOH from a division to a mere branch of the agency. The officials say that DOH does not receive enough funding annually to be considered a division. The ADA counters that now is not the time to lower oral health's profile, particularly given that dental caries remains the single most common childhood disease.

The **Health Resources and Services Administration (HRSA)** funds dental residencies, works to increase awareness of the connection between oral health and overall health, promotes prevention, and improves oral health literacy to health providers and patients. HRSA promotional efforts include working with the Institute of Medicine on its recent "Oral Health Initiative." HRSA also provides grants to communities for sealant programs and school-based treatment. The ADA lobbies every year to address what it sees as chronic underfunding of HRSA and its programs.

HRSA oversees the system of **federally qualified health centers (FQHCs)**, with more than \$2 billion annually going toward the services the centers provide to lower-income people, mostly the uninsured and Medicaid enrollees. As a major access point for care besides the emergency room, most community health centers provide dental care along with many other critical health care services. Only about one-fifth of health centers' budgets come from HRSA grants. Other financial support comes from Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), the Public Health Service, other government programs, patients' payments, and independent sources such as foundations. The ADA advocates for increased collaboration among dentists working in health centers and those working within private practice. Working together, these dentists can strengthen the dental public health infrastructure to better meet the oral health needs of the underserved within their communities.

The **Indian Health Service (IHS)** provides health care services to one of the most underserved populations in the country. IHS dentists and their teams work in rural areas, on tribal lands, and at urban locations, wherever the agency has determined a need. Until recently, IHS fell short of attracting dentists to fill the positions it felt were necessary to provide adequate care to targeted populations around the country. In the past few years, however, the agency has made great strides in filling those slots, largely as the result of proper funding appropriated by Congress. The ADA lobbies Congress every year to stress the importance of IHS's dental health programs and to urge proper funding for clinics and staff.

The **National Institute for Dental and Craniofacial Research (NIDCR)** is the federal government's principal agency dedicated to oral health research, both on its own campus in Maryland and through funding at various academic centers around the country. Research topics include dental caries, craniofacial development, dental materials, and bone diseases. The ADA is a consistent champion of NIDCR, lobbying for funding for the institute and fighting off attempts to subsume it within the larger National Institutes of Health system.

Head Start and **WIC** (the supplemental nutrition program for women, infants and children) both pay for or require enrollees to be provided dental services.

It is worth noting that as critical as these federal dental programs can be, the private practice dental community remains the backbone of the oral health care delivery system. Government programs that seek to increase the availability of dental care to people who need it *and seek it* succeed based on how effectively they link to the private practice dentists who deliver the vast majority of that care.

If you are interested in receiving more frequent bulletins and legislative action alerts relating to federal programs that help disadvantaged Americans attain better oral health please send a note to govtpol@ada.org. You will not be added to any lists other than this one, and you can opt out at any time.