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James J. Crall, DDS, ScD  
John Rossetti, DDS, MPH  
Don Schneider, DDS, MPH  
c/o National Oral Health Policy Center  
1100 Glendon Avenue, Suite 850  
Los Angeles, California 90024-6946

Dear Drs. Crall, Rossetti and Schneider:

As President of the American Dental Hygienists' Association (ADHA), I write to express ADHA's disappointment and concern with the National Oral Health Policy Center's October 2007 technical issue brief entitled "*Assuring Comprehensive Dental Services in Medicaid and Head Start Programs: Planning and Implementation Considerations*," and to respectfully ask that a revised brief and/or a statement of clarification be issued.

The brief criticizes "non-traditional alternative approaches to address dental access problems" in Medicaid because they do not "involve provision of services by dentists in private offices." Ironically, the very reason for the development of "non-traditional alternative approaches" in the first place was the failure of the traditional delivery system to adequately reach underserved populations. It is not for lack of desire or lack of effort that difficulties occur in linking patients seen by dental hygienists in public health settings with dentists in private practice, but rather the lack of dentists who will see Medicaid or Head Start children, the lack of transportation, and the lack of time off for caregivers - to name a few of the major obstacles. Hygienists currently do and continue to want to work with dentists to meet the comprehensive oral health needs of patients that may lie outside of the scope of practice of dental hygiene.

Given the widespread recognition of the need to improve access to oral health services for Medicaid and Head Start children, it is extremely disconcerting that the brief uses technical jargon to mislead policymakers into thinking that unsupervised dental hygienists may not be reimbursed by Medicaid for oral health services. In fact, federal Medicaid rules allow such reimbursement and have for more than ten years. Oral health services provided by dental hygienists are coverable under Medicaid pursuant to 42 CFR 440.60 as "services provided by licensed practitioners within the scope of practice as defined under State law." The federal Medicaid Bureau agreed to this expansive interpretation in 1997 because the severity of the oral health access crisis and the inability of the traditional dental delivery model to meet the needs of the nation's most vulnerable absolutely demanded alternative delivery models.

More recently, in a meeting on November 7, 2007, Dr. Conan Davis, Chief Dental Officer at the Centers for Medicare and Medicaid Services, confirmed to ADHA that unsupervised dental hygiene services are coverable under federal Medicaid rules. Indeed, twelve states (California, Colorado, Connecticut, Maine, Minnesota, Missouri, Montana, Nevada, New Mexico, Oregon, Washington and Wisconsin) currently allow such coverage and reimburse dental hygienists for their services.

The brief also confuses the issues of independent practice, supervision and remuneration for services. Medicaid reimbursement for unsupervised dental hygiene services does not equate to independent dental hygiene practice, which is a business model; nor does Medicaid reimbursement for unsupervised dental hygiene services mean there is no link to additional services outside the dental hygiene scope of practice.

Another strong concern is that the brief could easily lead policymakers new to the oral health arena to conclude that alternative delivery models are not worthy of contemplation. The brief ominously warns that "policymakers considering alternative practice models should do so carefully." Alternative models do not seek to supplant the role of the dentist; they serve as a mechanism to open additional entry points into the health care delivery system in order to reach as many children as possible to provide oral health services by dental hygienists or other non-dentists while making referrals for needed additional care that cannot be provided within the dental hygienist's or other non-dentist's scope of practice. ADHA has heard from a number of dental hygienists who work in public health settings that the brief is creating confusion about the legality of Medicaid coverage of unsupervised dental hygiene services. From an access to care perspective, the uncertainty created by the brief is truly unfortunate.

The consideration of alternative delivery models is not only widespread today but it is virtually inevitable that the nation will see further consideration of new ways of delivering oral health care. The Institute of Medicine is contemplating a dental workforce study. The children's health insurance bill recently vetoed by President Bush calls for an examination of the feasibility and appropriateness of using qualified mid-level dental health providers, in coordination with dentists, to improve access for children to oral health services. The lack of any data within the brief to substantiate the authors' hypotheses that alternative dental service delivery models may not work should be duly noted.

The brief also fails to highlight the dental workforce challenges that greatly impact the delivery of care for those enrolled in Medicaid and Head Start programs. An average of 6,000 dentists retire annually while little more than 4,000 dental school graduates enter the workforce each year. The 2004 Report of the National Advisory Committee on Rural Health and Human Services noted that "the acute shortage of dentists is expected to worsen in the coming years." The declining dentist/population ratio is an enormous barrier to care with which state and local Medicaid and Head Start programs must contend. Administrators struggle to find dentists to provide the Early and Periodic Screening, Diagnosis, and Treatment services required by the federal government. A report issued by the Department of Health and Human Services entitled

*Children's Dental Services Under Medicaid: Access and Utilization* noted that less than one in five Medicaid-enrolled children access preventive dental care in a given year.

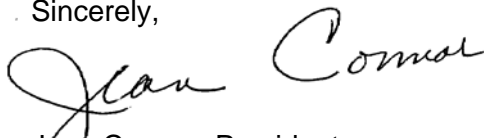
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While, as the brief maintains, increasing Medicaid reimbursement rates for services is an important component in increasing provider participation in Medicaid and Head Start programs, it alone will not solve access to care issues. Developing new and flexible solutions that make the most of the existing workforce and available resources is necessary to ensure that an increasing number of vulnerable children receive oral health care services.

Given the significant mischaracterizations described above, ADHA respectfully urges that a revised brief and/or a statement of clarification be issued. I look forward to hearing how you wish to proceed.

Please contact me, or Ann Battrell, ADHA Executive Director, through ADHA's Executive Office at 312-440-8911. We are committed to working with you and with all in the oral health and public health communities to positively, creatively and innovatively promote access to comprehensive dental services for the nation's most vulnerable, including Medicaid and Head Start children.

Sincerely,



Jean Connor, President  
American Dental Hygienists' Association

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