Introduction
The American Dental Hygienists’ Association (ADHA) appreciates this opportunity to provide testimony of FY 2017 appropriations. Oral health is a part of total health and authorized oral health care programs require appropriations support in order to increase the accessibility of oral health services, particularly for the underserved. While virtually all dental disease is fully preventable, nearly 25,000,000 children eligible for dental Medicaid benefits (60%) did not receive any preventive dental services in FY 2014.\(^1\) With the nation confronting an oral health access crisis, there is no dispute that new types of dental providers are needed; the disagreement relates to what types of new providers are needed. This underscores the need for demonstration projects under Section 340G-1 of the Public Health Service Act in order to explore what types of new providers work best in various settings. Regrettably, there is a persistent appropriations statutory provision blocking funding specifically for this grants program at the Health Resources and Services Administration (HRSA). There is simply no legal or health policy justification to perpetuate this funding block. Indeed, it is only organized dentistry that actively works to block funding for Section 340G-1. ADHA, along with the Kentucky Dental Hygienists’ Association and state dental hygiene associations across the nation, urges that the block on funding for Section 340G-1 be lifted, that $2,000,000 be appropriated for Section 340G-1 and that the following report language be included in the FY 2017 HHS funding bill:

\(^1\) [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html)
Requested Report Language: “The nation continues to confront an oral health access crisis, which will not be ameliorated without better utilization of existing dental providers and exploration of new types of licensed dental providers. The Committee urges a stakeholder meeting be convened in order to determine how best to create new entry points into the oral health care delivery system for rural and other underserved populations, better utilization of existing dental personnel, and exploration of new types of dental providers.”

Lifting the block on this dental workforce grants program, officially titled the Alternative Dental Health Care Providers Demonstration Program, would send an important signal to states and to HRSA that innovation in dental workforce is a meritorious undertaking. Even lifting the block and not funding the program would be a positive message to states. Importantly, the authorizing language requires that the grants be conducted in compliance with state law, that they must increase access to dental health care in rural and other underserved communities, and that the Institute of Medicine provide a qualitative and quantitative evaluation of the grants. Importantly, nothing in Section 340 G-1 would enable oral health practitioners to perform dental surgery or “irreversible procedures,” unless a state specifically allowed such services. Further, because the authorizing language requires HRSA to begin the dental workforce grant program under Section 340G-1 within two years of its 2010 enactment (i.e., by 2012) and to conclude it within seven years of enactment (2017), language directing HRSA to move forward with Section 340G-1 grants despite this timeline is needed.

Widespread Support for Dental Workforce Innovation
The American Dental Association (ADA), ADHA and numerous other groups have called for the creation of new types of dental providers. Innovative oral health practitioner models were authorized in Minnesota in 2009, followed by Maine in 2014. A February 2014 Report to the Minnesota Legislature on the early impact of the new providers found that benefits include “direct cost savings, increased dental team productivity, improved patient satisfaction and lower appointment fail rates.”2 Several states have mid-level oral health practitioner legislation pending including Connecticut, Georgia, Hawaii, Kansas, Massachusetts, New Mexico, North Dakota, South Carolina, Texas, Vermont and Washington State.

Both the W.K. Kellogg Foundation and the PEW Charitable Trust Dental Campaign are investing in state efforts to increase oral health care access by adding new types of dental providers to the dental team. Groups as disparate as Families USA, Americans for Tax Reform, and Americans for Prosperity have called for exploration of new dental providers. In a January 2015 report, Families USA called for “improving access to care through greater use of mid-level providers such as nurse practitioners and dental therapists”.3 Grover Norquist, President of Americans for Tax Reform, observed in March 2015 that “It is undeniable that there is a dentist shortage”. Norquist further noted that “Innovative ideas like this [mid-level dental provider] faced intense opposition but are very similar to the fights that took place decades ago with the

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2 http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf
emergence of nurse practitioners.” Americans for Prosperity wrote in January 2015 that states should be “free to innovate” in the dental workforce to solve access issues.

The National Dental Association, representing 6,000 Black dentists, released its “Position on Access to Care and Emerging Workforce Models” in July 2014, which stated that the NDA “supports the development and continuation of demonstration projects that can demonstrate the impact and effectiveness of Emerging Workforce Models [expanded function dental hygienists, expanded function dental assistants, or dental therapists] on access to care, and total health outcomes.”

The U.S. Federal Trade Commission (FTC) supported dental workforce expansion in November 2014, noting that expanding the supply of dental therapists is “likely to increase the output of basic dental services, enhance competition, reduce costs and expand access to dental care.” In January, 2016, the FTC noted that “By eliminating the direct supervision requirement for dental hygienists’ services delivered in expanded safety-net setting...H.B. 684 will likely promote greater competition in the provision of preventive dental care services, leading to increased access and more cost-effective care....” Importantly, the FTC observed that “authoritative sources have found no countervailing health or safety benefits to health care consumers from such [direct supervision] requirements.”

The National Governors Association’s January 2014 issue brief on “The Role of Dental Hygienists in Providing Access to Oral Health Care” found that “innovative state programs are showing that increased use of dental hygienists can promote access to oral health care, particularly for underserved populations, including children” and that “such access can reduce the incidence of serious tooth decay and other dental disease in vulnerable populations.”

The Department of Health and Human Services, in its Oral Health Strategic Framework, called for expanding the number of health-care settings that provide oral health care and urged strengthening the oral health workforce and expanding the capabilities of existing providers.

Dentist Shortage and Dental Hygienist Surplus Demand Better Utilization of Dental Hygienists

In February 2015, HRSA projected that all 50 states and the District of Columbia will experience a shortage of dentists by 2025. In contrast, there will be an excess supply of dental hygienists

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4 [http://ndaonline.org/position-on-access-to-care-and-emerging-workforce-models]
7 Ibid.
[http://www.publichealthreports.org/issueopen.cfm?articleID=3498]
at the national level while five states (MI, MT, ND, SD, and WV) will experience dental hygienist shortages from 21-93 FTEs.\(^\text{10}\)

**Title VII Program Grants to Expand and Educate the Dental Workforce –**

**ADHA Urges Funding at a level of $35.8 million in FY 2017**

A number of existing grant programs offered under Title VII support health professions education programs, students, and faculty. ADHA is pleased dental hygienists are recognized as primary care providers of oral health services and are included as eligible to apply for several grants offered under the “General, Pediatric, and Public Health Dentistry” grants. With millions more Americans eligible for dental coverage in coming years, it is critical that the oral health workforce is bolstered. Dental and dental hygiene education programs currently struggle with significant shortages in faculty and there is a dearth of providers pursuing careers in public health dentistry and pediatric dentistry. Securing appropriations to expand the Title VII grant offerings to additional dental hygienists and dentists will provide much needed support to programs, faculty, and students in the future.

**Oral Health Programming within the Centers for Disease Control –**

**Fund at a level of $19 million in FY 2017**

ADHA joins with others in the dental community in urging $19 million for oral health programming within the Centers for Disease Control. This funding level will enable CDC to continue its vital work to control and prevent oral disease, including vital work in community water fluoridation. Federal grants will serve to facilitate improved oral health leadership at the state level; support the collection and synthesis of data regarding oral health coverage and access, promote the integrated delivery of oral health and other medical services; enable states to be innovative and promote a data-driven approach to oral health programming.

**National Institute of Dental and Craniofacial Research –**

**Fund at a level of $452 million in FY 2017**

The National Institute of Dental and Craniofacial Research (NIDCR) cultivates oral health research that has led to a greater understanding of oral diseases and their treatments and the link between oral health and overall health. Research breeds innovation and efficiency, both of which are vital to improving access to oral health care services and improved oral status of Americans in the future. ADHA joins with others in the oral health community to support NIDCR funding at a level of $452 million in FY 2016.

**Conclusion**

ADHA is the largest national organization representing the professional interests of more than 185,000 licensed dental hygienists across the country. Thirty-nine states enable patients to directly access oral health services provided by dental hygienists in settings outside the private dental office. Seventeen State Medicaid programs (AZ, CA, CO, CT, ME, MA, MI, MN, MO, MT,  

\(^{10}\) HRSA March 2015 “National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025”  

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NE, NM, NV, OR, RI, WA and WI) provide direct reimbursement to dental hygienists for oral health services provided to Medicaid-eligible individuals.

**ADHA urges the Subcommittee to lift the block on funding for Section 340G-1 of the PHSA, dental workforce demonstration grants, in its FY 2017 HHS funding bill. It is time for an evidence-based decision to be made on this grant program for the underserved.** Lifting the block on funding for these dental workforce grants would be an important signal to states and to health care stakeholders that exploring new ways of bringing oral health services to the underserved is a meritorious expenditure of resources. Without the appropriate supply, diversity and distribution of the oral health workforce, the current oral health access crisis will only be exacerbated.

In closing, ADHA recommends funding at a level of $2 million for FY 2017 to support these vital dental workforce demonstration projects. ADHA also requests that report language (see page 2) be included noting that the Committee recognizes that the oral health access crisis will not be ameliorated without better utilization of existing dental providers and exploration of new types of licensed dental providers. In addition, ADHA urges that this Subcommittee convene a stakeholder meeting in order to move beyond the tired appropriations rider that blocks funding for Section 340G-1, a dental workforce demonstration program to improve access to care for vulnerable and underserved populations. Thank you for the opportunity to submit the views of the ADHA.