American Academy of Pediatric Dentistry

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Recommendations for pediatric oral health care in health care reform legislation

The Board of Trustees of the American Academy of Pediatric Dentistry (AAPD), in accord with the oral health policies, clinical guidelines, and legislative and regulatory priorities of the AAPD, has summarized critical recommendations for health care reform legislation concerning pediatric oral health care. These are focused on the most critical oral health access needs of children:

1. **Given the continued shortage of pediatric dentists and shortages of faculty to train dentists who treat children, include a re-authorization of Title VII dental primary care training programs by creating a cluster for pediatric, general, and public health residencies with expanded authority for faculty loan repayment (per H.R. 1930), faculty development (including faculty salary supplements), academic administrative units, and pre-doctoral training. This should be authorized at $30 million annually.**

2. **Improve Medicaid dental programs via sec. 201 of the Essential Oral Health Care Act (H.R. 2220) by increasing the Federal Medical Assistance Percentage (FMAP) for dental services by 25 percent for states that meet certain quality criteria including: adequate child enrollment in plans; payment for dental services for children at levels consistent with the market-based rates; at least 35 percent of the practicing dentists participating in the plan; and a reduction in administrative barriers.**

3. **Provide greater federal (CMS) oversight of Medicaid dental programs in several areas, including ensuring that all State Medicaid/EPSDT programs develop and maintain dental periodicity schedules that are consistent with contemporary recommendations for quality pediatric dental care, and that these schedules are used to evaluate Medicaid/EPSDT dental program performance.**

4. **Promote the establishment of a dental home[1] for every child by creating incentives for the provision of dental insurance via employer or individual purchase; conversely, do not tax employer-provided dental benefits, which would decrease access and increase medical and dental costs for those already receiving preventive dental care. Dental benefit plans must also be available for coverage of patients with special health care needs as they "age out" of child programs to adult coverage.**

5. **Support one level of oral health care for all children. Encourage states to adopt programs that utilize the existing care delivery system rather than divert resources to create unproven and costly alternatives that would take years to create while needlessly delaying critical and compassionate oral health care to children. Encourage states to adopt Expanded Functions for Dental Assistants (EFDA). Such training programs have been in place and functional for years, have tested curricula, and the dental community has already embraced their role in the Dental Home.**

For additional information about these recommendations: slitch@aapd.org

[1] The AAPD defines a dental home as " . . . the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate."

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