

# Financing Oral Health Services for People With Special Needs: Projecting National Expenditures

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## Abstract

Low-income people with disabilities or who are elderly have more dental disease, more missing teeth, and more difficulty obtaining dental care than other members of the general population. These realities lead to untreated infection, increased medical costs and needless suffering for the most vulnerable members of our society. It is critical we provide adequate reimbursement for oral health services in order to avoid the tragic and costly consequences of oral neglect. This article focuses on the financial implications of delivering oral health services to low-income individuals who are “aged, blind, and disabled” in the United States. The experience of providing oral health services in California for these populations is extrapolated to predict the cost implications of a national reimbursement system for ABD adults under Medicaid and reform Medicaid oral health programs for vulnerable children. The new federal dollars required to implement this legislation would be more than offset by a conservatively estimated 0.5 percent reduction in costly emergency room and hospital charges for the treatment of serious dental problems, as well as a reduction in the prevalence and severity of several general health conditions. Treating and/or preventing oral infection and disease for the ABD populations in our country will significantly reduce overall health care costs, improve quality of life, and end needless suffering for America’s most vulnerable citizens. Treating and/or preventing oral infection and disease for this population simply is the right thing to do.

There is extensive literature demonstrating that people with disabilities have more dental disease, more missing teeth, more chewing problems, and more difficulty obtaining dental care than other members of the general population.<sup>1-6</sup> These realities lead to untreated infection, increased medical costs, decreased quality of life, and needless suffering for the most vulnerable members of our society. This literature and the conclusion that this situation is growing worse are reviewed in the previous issue of this journal.<sup>7</sup> The consensus statement contained in that issue lists a number of problems with the ability of the current oral health care system to meet the needs of people with disabilities and presents recommendations designed to address those problems.<sup>8</sup> Among these is the recommendation to provide adequate reimbursement for oral health services in order to avoid the tragic and costly consequences of oral neglect. This article focuses on the financial implications of delivering oral health services to low-income people who are defined by the Social Security Act as “aged, blind,



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and disabled” in the United States and eligible for services under the Medicaid program. California’s experience of providing oral health services to adult ABD Medicaid recipients is extrapolated to predict the costs of a national oral health program targeted to serve this population.

### Medicaid and the “Aged, Blind and Disabled” Population

The number of people with special needs who need oral health services is rising dramatically.<sup>7</sup> In this context, people with special needs refers to people who have difficulty having good oral health or accessing oral health services because of a disability or medical condition. The U.S. Census reported in 2000 that 49.7 million people in the country’s population had a long-standing condition or disability.<sup>9</sup> They represented 19.3 percent of 257.2 million people who were aged 5 and older in the civilian noninstitutionalized population, or nearly one person in five. Further, the 2000 census reported that people with disabilities were far less likely to be employed than nondisabled people, and were far more likely to have incomes at or below the federal poverty level. The proportion of young people with disabilities who were below the federal poverty level was 25.0 percent, compared with 15.7 percent for those without disabilities. The next highest proportion of individuals below the federal poverty level for both groups was found among people 16 to 64 years old — 18.8 percent for those with disabilities; nearly double the rate for those without (9.6 percent). Among people 65 years old and over, the respective proportions were 13.2 percent and 7.4 percent.

Medicaid is an important source of health care coverage for the low-income aged, blind, and disabled populations in America. The Medicaid program is

administered at the federal level by the Centers for Medicare and Medicaid Services, formerly called the Health Care Financing Administration, within the U.S. Department of Health and Human Services. While states have flexibility in determining the criteria they use to define this population, every state has a defined population in their Medicaid program that fits into the categories of “aged, blind, and disabled.”<sup>10,11</sup> In general, to be classified as a Medicaid-eligible ABD adult, the individual must fit into one of the defined categories and have an income that is equal to or below the state’s income standard, the

**Optional groups include certain ABD adults who have incomes above those requiring mandatory coverage but below the federal poverty level.**

maximum amount of income a person can have and still be eligible. States have certain groups of people, including certain aged, blind, and disabled individuals whose coverage is mandatory and other groups whose coverage is optional. These optional groups include certain ABD adults who have incomes above those requiring mandatory coverage but below the federal poverty level.<sup>12</sup>

Medicaid represents the second largest category of state spending and the largest share of federal funding provided to states.<sup>13</sup> This is illustrated in **Figure 1**. In the United States in 2002, there were 39.9 million people enrolled in Medicaid programs. Of these 11.7 million, or 29 percent, were categorized in one of the ABD groups. In 2004, there were 42.2 million people enrolled in Medicaid

programs. Of these 12.2 million, again in 2004, 29 percent, were categorized in one of the ABD groups.<sup>14,15</sup> Nationally, the disabled population enrolled in Medicaid grew by more than 50 percent during the 1990s.<sup>16</sup> CMS reported that in California in 2000, those individuals enrolled in the state’s Medicaid program represented 23.7 percent of the total state population while the Public Policy Institute of California reported this figure to be around 19 percent for 2000 and 21 percent in 2003.<sup>17,18</sup>

In California, the state’s Medicaid program, Medi-Cal, is administered by the California Department of Health Services. DHS reported in 2002 that there were 6.5 million people eligible for Medi-Cal in the 2002-03 fiscal year.<sup>19</sup> Of these, 1.5 million or 24 percent were in ABD categories. DHS also reported that 52 percent of Medi-Cal eligible individuals are adults.<sup>20</sup>

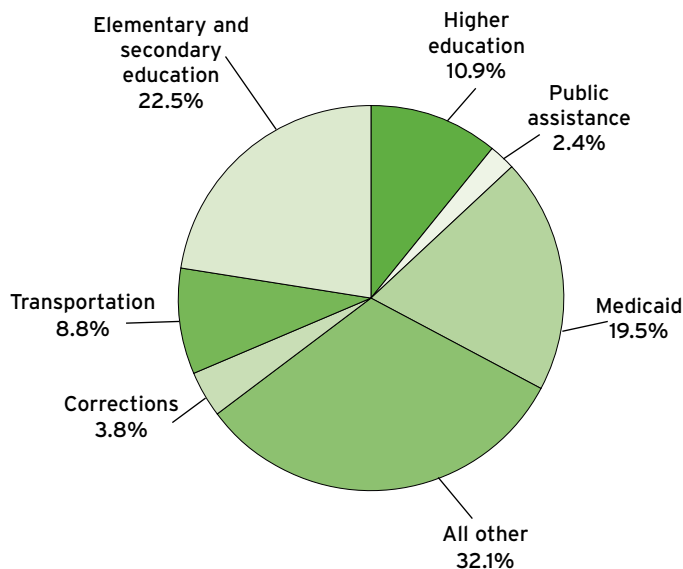
Nationally, people who are categorized as aged, blind, or disabled use a much larger share of total Medicaid expenses than their share of the eligible population. As illustrated in **Figure 2**, in 1999, the ABD groups represented 28 percent of the total U.S. Medicaid beneficiaries. However, they accounted for 72 percent of the total U.S. Medicaid payments.<sup>13</sup> As demonstrated in this article, this disproportionate share of expenditures does not exist with payments for dental benefits. Focusing resources on improving the general health of the ABD population should result in significant expenditure reductions for federal and state governments.

ABD individuals also constitute almost all of the Medicare population. In 2003, there were 41.1 million total Medicare enrollees. Of these, 35 million were classified as aged and 6.1 million as disabled.<sup>21</sup> It should also be noted that there are many Medicare recipients who are also eligible for Medicaid.<sup>22</sup> In 1997, they accounted for 19 percent of

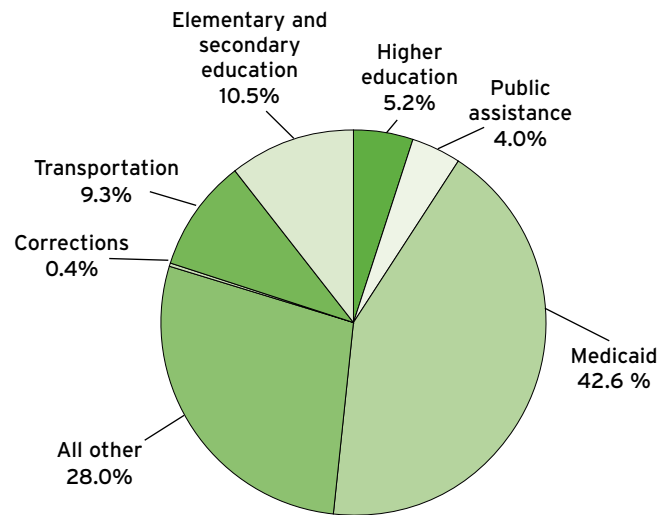
## Total State Spending and Federal Funds Provided to States, 2000

More than 19 percent of state total spending and more than 42 percent of federal funds provided to states were spent on Medicaid.

Total state spending\*



Federal funds provided to states



\*Note: When only general funds are examined, the proportions change somewhat. Medicaid is the second-largest state program in either total or general funds.  
Source: National Association of State Budget Officers, 2000 State Expenditure Report.

**Figure 1.** State and federal Medicaid expenditures.<sup>13</sup>

the Medicaid eligible population but were responsible for 35 percent of the Medicaid expenditures in that year. There were about 38 million aged and disabled Medicare enrollees in 1997.<sup>23</sup> That means that dual eligible ABD individuals constituted 17 percent of the total Medicaid enrollees. In 2002, CMS reported that 22 percent were dual eligible.<sup>24</sup> Because Medicaid is the payer of last resort, Medicare pays for most of the costs of the health care provided to beneficiaries with dual eligibility.<sup>25,26</sup>

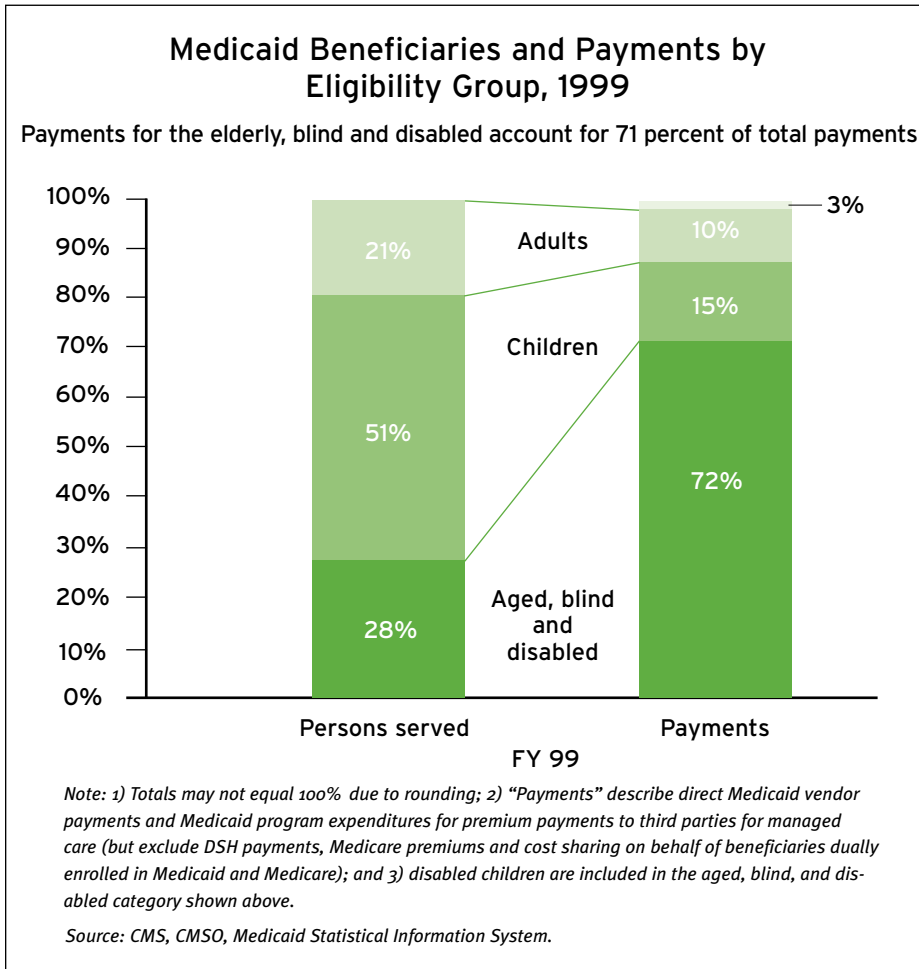
Medicaid is funded partly by the federal government and partly by the states. The federal government matches

state expenditures under the Medicaid program. The amount matched is determined by a formula based on the Federal Medical Assistance Percentages.<sup>27</sup> The FMAP varies from state to state with the lowest amount being 50 percent. States with lower average income per person receive a higher FMAP. For example Mississippi receives 77.3 percent of their Medicaid expenses as reimbursement from the federal government, while California receives 50 percent. States can receive an enhanced FMAP for certain services under the Social Security law.<sup>28</sup> Some examples of these enhancements include Section 1923(a)(1) payments

for hospitals to “take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs;” Section 1903(a)(2)(B) payments for nursing aid training and competency evaluation; and Section 1903(a)(2)(C) which provides for reimbursement at 75 percent for costs attributable to preadmission screening and resident review activities in nursing facilities.

### Dental Coverage Under Medicaid

The federal Medicaid program mandates that certain services be provided to eligible recipients. In addition there are



**Figure 2.** Medicaid eligibility vs. payments, 1999.<sup>13</sup>

a series of optional benefits that may be implemented by the states and receive federal matching funding.<sup>29</sup> Required services include inpatient hospital services, outpatient hospital services, and physician services and dental services for children. Optional benefits include optometrist services and eyeglasses, prosthetic devices, and dental services for adults.

Unfortunately, most states have decided not to provide adults dental services as a benefit. In March 2003, the Kaiser Commission on Medicaid compiled a report for the National Conference of State Legislatures on

state Medicaid adult dentistry benefits. This data is available on the Kaiser Commission website.<sup>30</sup> An update on this data, prepared for the National Conference of State Legislatures, revealed that in 2000, there were 14 states with full dental Medicaid benefits for adults. In 2005, there were only seven. In the same time frame, states with only emergency oral health services or no oral health services for adults rose from 20 to 26.<sup>31</sup> Because of these state decisions, the vast majority of adult Medicaid recipients in the United States have inadequate or no dental benefits. In some states, there may be

funding for extractions as a treatment for dental emergencies. In other states, even this option is not available for our most vulnerable citizens. In these states, there are **no** dental services available for these populations.

**Consequences of Inadequate Oral Health Funding for Adults Under Medicaid**

Untreated dental disease leads to infection, pain, and even death. For millions of low-income aged, blind, or disabled Americans in states with inadequate or no dental benefits, suffering with untreated dental disease and infected mouths and bodies is the norm. Some of these individuals are slightly better off, yet they live in states where removing all of their teeth is their only option.<sup>32</sup> Individual stories of neglect, pain, and suffering, however, are not the only consequence of this situation. There are significant economic consequences as well.

There are many situations where huge medical costs have resulted from the lack of available dental services. In Louisiana in 2003, a \$70 extraction would have saved an elderly patient 15 days in the hospital, including two days in an intensive care unit, and a \$35,000 medical bill.<sup>32</sup> In California, a young autistic lady who was nonverbal began to act out and hit other residents of her community residential care facility. She was admitted to a locked psychiatric facility at a cost of \$150,000 per year to the State of California. Fortunately, it was eventually discovered she had dental problems. Once her dental problems were treated, her acting out behaviors ceased and she was able to return to her community. The Pacific Center for Special Care at the University of the Pacific Arthur A. Dugoni School of Dentistry produced a moving video of these events.<sup>33</sup>

Another economic consequence of the lack of Medicaid coverage for adult

dental treatment occurs when people turn to costly emergency room visits for treatment of dental pain and infection. In 1993, when Maryland eliminated Medicaid reimbursement to dentists for treatment of adults with dental emergencies, there were subsequent increases in medical costs. The rate of emergency room visits for dental problems rose by 12 percent.<sup>34</sup> A related study demonstrated that 2 percent of dental-related emergency department visits resulted in a hospital admission with a mean cost of \$5,793.<sup>35</sup>

Less obvious to many people but of huge economic consequence, are the general health sequelae of untreated dental disease. There is increasing evidence of the association of dental disease, particularly periodontal disease, with general health conditions. Recent evidence has provided strong evidence of a causal link with certain conditions. The Association of State and Territorial Health Officials has hypothesized that providing dental care under Medicaid could lower costs for treating heart disease.<sup>36</sup> This conclusion was based, in part, on recent data linking the progression of atherosclerosis to the presence of bacteria that cause periodontal disease. This study indicated that the higher the levels of the periodontal disease-causing bacteria and the more teeth lost, the more likely people were to have thicker carotid arteries.<sup>37</sup> An earlier study demonstrated a correlation between tooth loss and carotid artery plaques.<sup>38</sup>

In addition to heart disease, there is evidence of the link between poor oral health and many other diseases. According to the Centers for Disease Control and Prevention, the second-leading cause of infant mortality is premature birth/low birthweight.<sup>39</sup> The NIH was quoted as reporting that “as many as 18 percent of the 250,000 premature low-weight infants born in the United States each year may be

attributed to infectious oral disease” and several studies have shown that mothers with severe or widespread periodontal disease have a higher risk of preterm delivery.<sup>40,41</sup> It has also been demonstrated that oral health problems are correlated with pneumonia. A study of nursing home-acquired pneumonia found that eight of 13 patients had bacteria in the lung genetically matched to

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dental plaque from those patients. The authors concluded that dental plaque may be an important reservoir of hospital-acquired pneumonia.<sup>42</sup> There is also an extensive literature on the relation between periodontal disease and diabetes that demonstrates that people with severe periodontal disease have more severe diabetes and a significantly greater prevalence of diabetic sequelae including stroke, transient ischemic attack, angina, myocardial infarction, heart failure, and intermittent claudication than did diabetic patients with minimal periodontal disease.<sup>43,44</sup> Links have also been established between periodontal disease and other general health conditions such as stroke.<sup>45-48</sup>

**The Importance of Preventing Chronic Diseases**

In a 2003 report, “The Power of Prevention,” the CDC emphasized the importance of prevention in improving the health of the nation and reducing

health care costs.<sup>49</sup> It pointed out that five chronic diseases — heart disease, cancer, stroke, chronic obstructive pulmonary disease (e.g., asthma, bronchitis, emphysema), and diabetes — cause more than two-thirds of all deaths each year. The number of deaths alone, however, fails to convey the full picture of the toll of chronic disease. In the same report, the CDC indicated that more than 125 million Americans live with chronic conditions, and millions of new cases are diagnosed each year. These serious diseases are often treatable but not always curable. Add to these diseases the presence of chronic untreated oral infection and the suffering and cost increases. These oral infections are, however, both treatable and preventable.

Chronic disease leads to disability and diminished quality of life. The CDC report on prevention pointed out that the United States spends more on health care than any other country in the world. In 1980, the nation’s health care costs totaled \$245 billion, an average of \$1,066 for each American. In 2001, the total health care cost in the United States was an astounding \$1.4 trillion.<sup>49,50</sup> This is an average of \$5,035 for each American. It was indicated that chronic disease accounts for roughly 75 percent of health care costs each year. The estimated cost of cardiovascular disease and stroke in 2003 was \$351.8 billion. Of this amount, \$209.3 billion was due to direct medical costs and \$142.5 billion to lost productivity.<sup>49,51</sup> The estimated cost of diabetes in 2002 was \$132 billion. Of this amount, \$91.8 billion was due to direct medical costs and \$39.8 billion to lost productivity.<sup>49,52</sup>

In 2004, the portion of total health expenditures contributed by Medicaid was \$298 billion and the proportion contributed by Medicare was \$284 billion.<sup>53</sup> In that year, the federal government contributed 60.2 percent of the total Medicaid expenditures and the



states contributed 39.8 percent.<sup>54</sup> Given that people who are aged, blind and disabled have accounted for 72 percent of the total U.S. Medicaid payments, the total Medicaid expenditures for the ABD population can be estimated to be about \$215 billion annually.<sup>13</sup> Also, as described earlier, Medicaid dual-eligible ABD individuals constitute about 22 percent of the total Medicare enrollees and can therefore be expected to be responsible for about \$64 billion in Medicare expenditures annually. If it were possible to save only 0.6 percent of these Medicaid and Medicare expenses by providing oral health services for these groups, this would result in a reduction in expenditures of \$1.7 billion with a \$1.2 billion expenditure reduction for the federal government and a \$0.5 billion reduction for the states. As can be seen from the subsequent analysis, this is more than enough savings to pay for dental coverage for adult ABD individuals in every state and improve funding for the critically underfunded children's oral health program.

As an example of the cost effectiveness of providing dental services to reduce general health costs, Offenbacher et al. estimated that 18.2 percent of all preterm low birthweight births may be attributable to periodontal disease in pregnant women, and that if these infections could be eliminated, approximately 45,500 preterm low birthweight newborns a year could be avoided nationally, with a concomitant decrease in neonatal intensive care unit costs of \$22,000 per baby, or almost \$1 billion.<sup>55</sup> California's Medicaid program used an extrapolation of this analysis to the number of live births financed by the program to estimate that the state and federal governments would collectively save more than \$29 million annually by providing several diagnostic and periodontal disease prevention and treatment benefits for pregnant women.<sup>56</sup>

It is clear there are staggering national expenditures being made to treat medical conditions of low-income individuals that may be caused, in part, by a lack of access to oral health services and consequent poor oral health. It is also clear that providing oral health services and preventing oral diseases can save significant general health expenditures.

### The Special Care Dentistry Act

Special Care Dentistry, the largest national organization devoted to improving the oral health and well-being of people with special needs, has

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proposed the Special Care Dentistry Act. The current version of this national legislation and a fact sheet for policy makers is available on the Special Care Dentistry website: [www.SCDonline.org](http://www.SCDonline.org).<sup>57</sup> This proposed legislation is endorsed and supported by all major dental organizations as well as an impressive list of advocacy groups. The Special Care Dentistry Act addresses the major health disparities caused by the lack of dental services available for low-income ABD populations by expanding federally required Medicaid coverage to include the nation's low-income aged, blind and disabled populations and supporting states by increasing federal funding for Medicaid oral health ser-

vices by creating a 90/10 federal/state match (FMAP of 90 percent). The Special Care Dentistry Act would not only help relieve the tremendous amount of pain, infection, and suffering experienced by our nation's low-income ABD populations, it would also be a cost-effective means of addressing the staggering national Medicaid general health care expenses for these populations. The Act also increases the federal/state match for the children's dental program to a 90/10 federal/state match.

The cost of the Special Care Dentistry Act was estimated by analyzing reports from the California Department of Health Services about Medi-Cal expenditures in 2004 and extrapolating this data to a national system. California provides fairly comprehensive Medicaid adult dental coverage and is therefore a model for the costs to be expected if the Special Care Dentistry Act were adopted. The California Medicaid dental program is referred to as Denti-Cal. Data was obtained from the Department of Health Services from an analysis of the department's MIS/DDS database about eligibility, users and dental expenditures by aid code and age in 2004.<sup>58</sup> Aid codes represent Medicaid categories of eligibility. This data was used to determine the number of eligibles, users, and expenditures for Medicaid adult dental services for the total and ABD populations. **Table 1**, line 4 shows that the adult ABD population represented 25 percent of the users of dental benefits and used 27 percent of the total Denti-Cal expenditures. **Table 2**, line 2 shows that the ABD adults represented 21 percent of the population eligible for dental services and 30 percent of them used dental services in 2004 (**Table 2**, line 5). Adult ABD eligible individuals averaged \$115.90 in dental expenditures during 2002 (**Table 2**, line 6).

The California data was used to estimate national users and expendi-

<b>Table 1</b>				
<b>California Medi-Cal Dental Program (Denti-Cal): Users and Expenses 2004<sup>58</sup></b>				
<b>Description</b>	<b>Users</b>	<b>%</b>	<b>Expenditures</b>	<b>%</b>
1. Total users, all ages	1,676,749	100%	\$571,288,289	100%
2. ABD users	450,118	27%	\$167,863,490	29%
3. % of total users who are adults		43%		71%
4. ABD adult users	412,094	25%	\$156,650,392	27%
5. Total cost of Denti-Cal children's program			\$299,315,157	52%

<b>Table 2</b>			
<b>California Medi-Cal Dental Program (Denti-Cal): Eligible Individuals 2004<sup>58,19,20</sup></b>			
<b>Description</b>	<b>Individuals/\$</b>	<b>% of Total</b>	<b>Notes</b>
1. Total eligible individuals	6,933,625	100%	
2. Eligible ABD individuals	1,470,708	21%	
3. Eligible individuals 21 and older (adults)	3,154,114	45%	
4. Eligible ABD adults	1,351,577	19.5%	
5. % of eligible ABD adult who use services		30%	Table 1, line 4 (users)/line 5
6. Annual expense for ABD-eligible adult	\$115.90		Table 1, line 4 (\$)/line 5

tures if there was adult dental coverage in all states as proposed in the Special Care Dentistry Act. Data from CMS was used to obtain the projected number of total individuals and ABD individuals who were eligible for Medicaid services in 2004, the latest year for which data was available.<sup>14</sup> By applying the percent of eligible adults who were in the ABD population (45 percent) and the expenditures per ABD adult in California, it is possible to estimate that providing dental coverage for all ABD adults nationally would cost about \$636 million annually (see **Table 3**, line 4).<sup>59</sup> However, these are not all new expenses. States like California already provide these

services. **Table 3**, line 5, uses the current expenditure/eligible ABD adult in California (**Table 2**, line 6 (\$)), the percent of Medicaid eligibles who are ABD adults (45 percent), and the total eligibles in other states that provide adult benefits (Conn., N.J., N.Y., N.D., Pa., Wis.) to estimate that there is currently \$331 million being spent on adult ABD benefits nationally (**Table 3**, line 5).<sup>59,17,31</sup> This is a conservative estimate because it does not count expenditures in states with limited adult dental programs. The federal share of these existing expenses if the FMAP was increased from 60.2 percent to 90 percent would be \$99 million (**Table 3**, line 6). Adding dental ben-

efits for the adult ABD population in other states would add \$305 million in new expenses (**Table 3**, line 7). The new federal share of this coverage with the FMAP of 90 percent is \$275 million (**Table 3**, line 8). This brings the total new federal expenditures for adult ABD coverage to \$374 million (**Table 3**, line 9). Finally, an estimate is added to the cost of increasing the federal share of the current children's program if the FMAP goes to 90 percent for that program as well. The California Medicaid population can be calculated to be about 15 percent of the total Medicaid population.<sup>60</sup> If the cost of the California children's program is divided by 15 percent and



the increased FMAP applied, there is a new federal cost of \$595 million for increasing the FMAP for the children's program to 90 percent (Table 3, line 11). This brings the estimate for the total new federal cost for the Special Care Dentistry Act to about \$968 million (Table 3, line 12). This cost represents less than 0.2 percent of the current total federal expenditures of

\$589 billion for health care under the Medicare and Medicaid programs.<sup>53</sup>

In order to estimate the true cost of building the national infrastructure for ABD adults to receive Medicaid dental benefits, it is also necessary to estimate the savings in medical costs that would result from these vulnerable populations having access to dental services across the nation. While it

is impossible to predict precisely what the savings in medical costs would be, the data presented in this article suggests that treating and preventing oral infections would indeed decrease general health expenditures through reduced reliance on emergency room care and very expensive hospitalizations for serious consequences of untreated dental infections. It is also

**Table 3**

**National Eligible, Users, and Estimated Expenses<sup>14</sup>**

Description	Individuals/\$	% of Total	Notes
1. National total Medicaid-eligible individuals <sup>14</sup>	42,400,000	100%	
2. National ABD-eligible individuals <sup>14</sup>	12,000,000	29%	
3. Estimated national ABD-eligible adults	5,490,000		Line 2 x 45% <sup>59</sup>
4. Estimated national cost for ABD-eligible adults	\$636,301,838		Line 3 x Table 2, line 6 (\$)
5. Estimated current expense for ABD adults	\$330,818,708		Table 2, line 6 (\$) x Table 2, line 5 (%) x total eligible in states with adult dental benefits (14,642,625) <sup>17,31</sup>
6. Increased federal share of current expense if FMAP goes from 60.2% to 90%	\$98,583,975		Line 5 x 29.8%
7. New costs for ABD-eligible adults	\$305,483,130		Line 4 less line 5
8. Federal share of new costs for ABD adults if FMAP is 90%	\$274,934,817		Line 7 x 90%
9. Increased federal cost for adding adult dental coverage for ABD population	\$373,518,792		Line 6 plus line 8
10. Estimated cost of children's Medicaid dental services	\$1,995,434,380		Table 1, line 5 (\$)/California share of national Medicaid population (15%) <sup>60</sup>
11. Increased federal share of estimated cost for children's coverage if FMAP goes from 58% to 90%	\$594,639,445		Line 9 x 29.8%
12. Total new federal cost for SCD Act	\$968,158,237		Line 8 plus line 10

likely that improved oral health would reduce the incidence of the numerous general health conditions known to be caused or exacerbated by oral infections. As described earlier, a conservative estimate of a 0.5 percent decrease in medical expenditures would result in a cost savings of \$1.4 billion for the total Medicaid program with about \$1 billion of that amount constituting federal savings. This is enough to pay for the cost of national Medicaid dental coverage for adults who are aged, blind, and disabled, our most vulnerable citizens, and reform Medicaid oral health programs for vulnerable children.

## Summary

People with low incomes who have disabilities or are elderly have the worst dental conditions of any population in the United States. While every state defines an aged, blind, or disabled population group within its Medicaid program, few states provide dental services for adults in this group. This results in widespread pain, suffering, and infection for these individuals. In addition, there is increasing evidence that poor oral health, particularly periodontal infections, can contribute to a number of general health conditions, all with significant costs for our country. Given that the ABD population accounts for the majority of Medicaid general health expenditures, there is an opportunity to reduce the suffering and save significant Medicaid expenditures.

The Special Care Dentistry Association has proposed legislation, the Special Care Dentistry Act, to provide Medicaid dental benefits for ABD adults nationally and reform Medicaid oral health programs for vulnerable children. This proposed legislation is endorsed and supported by all major dental organizations as well as an impressive list of advocacy groups. A

projection of the costs of implementing this legislation was performed using data from the California's Medicaid dental program. The new federal dollars required to implement this legislation would be less than \$1 billion. This amount would be offset by a conservatively estimated 0.5 percent reduction in costly emergency room and hospital charges for the treatment of serious dental problems, as well as a reduction in the prevalence and severity of several general health conditions.

Treating and/or preventing oral infection and disease for the ABD populations in our country will significantly reduce overall health care costs, improve quality of life, and end needless suffering for America's most vulnerable citizens. Treating and/or preventing oral infection and disease for the aged, blind, and disabled population simply is the right thing to do. **CDA**

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