Oral Health System: Pandemic Response Working Group
Virtual Meeting
July 21, 2021
4:00-5:30 pm ET

Group Memory

Convenor:
Michael Monopoli, Vice President, Grants Strategy
CareQuest Institute for Oral Health

Facilitator:
Patrick Finnerty, Strategic Advisor
CareQuest Institute for Oral Health

Content Manager:
Sara Oaklander, Interaction Institute for Social Change

Table of Contents

I. Participants

A. Pandemic Response Workgroup

The following Pandemic Response Workgroup members were present at the meeting.

Name	Organization
Vanetta Abdellatif, MPH	President and CEO, Arcora Foundation
Eme Augustini	Executive Director, National Association of Dental Plans
Ann Battrell, MDSH	Chief Executive Officer, American Dental Hygienist Association
Latisha Canty, RDH, MS	President-Elect, National Dental Hygienist Association
Gregory Chavez	Chief Executive Officer, Dental Trade Alliance
Manuel A. Cordero, DDS, CPH, MAGD	Executive Director & Chief Executive Officer, Hispanic Dental Association
Terri Dolan, DDS, MPH	President-Elect, Santa Fe Group
Susan Flores	Senior Policy Coordinator, California Pan-Ethnic Health Network
Steve Geiermann, DDS *(for Jane Grover)*	American Dental Association
Ifetayo Johnson, MA	Executive Director, Oral Health Progress and Equity Network
Steve Kess, MBA	VP, Global Professional Relations, Henry Schein
Sarah Miller, MPA	Director of Philanthropy and Foundation Operations, Dental Trade Alliance
Myechia Minter-Jordan, MD, MBA	President and CEO, CareQuest Institute for Oral Health
Mike Monopoli, DMD, MPH, MS	VP, Grants Strategy, CareQuest Institute for Oral Health
Gary Pickard (*for Mitch Goldman)*	Association of Dental Services Organizations
Colin Reusch	Senior Advisor, Oral Health Policy, Dental Access Project Community Catalyst
RADM Tim Ricks, DMD, MPH, FICD	Chief Professional Officer, USPHS, OHCC, IHS
Emmett Scott	Association of Dental Service Organizations
Tonia Socha-Mower, MBA, EdD	Executive Director, American Association of Dental Boards
Barbie Vartanian	Executive Director, Project Accessible Oral Health
Marko Vujicic, PhD	Chief Economist and VP, American Dental Association
Brett Weber	Public Health Policy & Programs Manager, National Indian Health Board
Robert Zena, DMD	President, American Association of Dental Boards

The following Pandemic Response Workgroup members were unable to attend today's meeting.

Name	Organization
Pamela Alston, DDS	President, National Dental Association
Stacy Bohlen	CEO, National Indian Health Board
Edwin A. del Valle-Sepulveda, DMD, JD	President, Hispanic Dental Association
Chelsea Fosse, DMD, MPH	Senior Health Policy Analyst, American Dental Association Health Policy Institute
Mitch Goldman, JD, MBA	Executive Committee, Association of Dental Services Organizations, and CEO, Mid-Atlantic Dental Partners
Jane Grover, DDS, MPH	Director, Council on Advocacy for Access and Prevention, American Dental Association
Hazel Harper, DDS, MPH	Past President, National Dental Association
LaVette Henderson	Executive Director, National Dental Association
Alan Morgan, MPA	Chief Executive Officer, National Rural Health Association
Diane Oakes, MSW, MPH	Chief Mission Officer, Delta Dental of Washington
Emily Stewart	Executive Director, Community Catalyst
Christine Wood	Executive Director, Association of State and Territorial Dental Directors
Vicki Young, PhD	COO, South Carolina PHCA and member of National Association of Community Health Clinics

B. Strategic Advisors and Staff

- Marcia Brand, PhD, former Deputy Administrator, Health Resources and Services Administration
- *(Not present)* Hannah Cardosi, Administrative Coordinator, CareQuest Institute for Oral Health
- Patrick Finnerty, former Medicaid Director for the Commonwealth of Virginia
- Marianne Hughes, former Executive Director, Interaction Institute for Social Change
- Kristin LaRoche, Vice President, Public Relations, CareQuest Institute for Oral Health
- Laurie Norris, JD, former Senior Policy Advisor for Oral Health, Centers for Medicare & Medicaid Services
- Bianca Rogers, PRW Working Teams Coordinator and Medicare Policy Advisor, CareQuest Institute for Oral Health
- *(Not present)* Al Yee, MD, MPH, Senior Advisor to Community Catalyst Dental Access Project and leader in health care, public health, and philanthropy

II. Start-Ups

A. Welcome

Mike Monopoli opened the meeting by welcoming everyone and thanking them for being here today.

We have a rich and full agenda this afternoon. A lot has happened since the last time we met – as always – there are some unique challenges – three steps forward, two steps back, but that's still progress!

Pat welcomed new member Brett Weber with the National Indian Health Board and Brett introduced himself.

B. Desired Outcomes

Pat reviewed the desired outcomes.

By the end of the meeting, the group expected to have:

- An opportunity to welcome new participants
- An update on the Biden Administration, including the Budget, and the COVID Health Equity Task Force
- An update on COVID-19, including the delta variant
- An update on the Surgeon General's report and next steps in advocacy and mobilization
- An update on progress on dental benefits in Medicare
- A shared understanding of the Working Team's proposal for collective action on Medicare
- An understanding of the HPI/CC/FUSA study on the fiscal impact of an adult dental benefit in Medicaid
- Agreement on next steps

III. Dental Benefits in Medicare

A. Update on Developments in Congress

Pat introduced Melissa Burroughs from Families, USA to speak to one of the Working Group's priorities - inclusion of an oral health benefit in Medicare - as there have been some recent and significant developments in Congress.

- There has been a lot of progress in the past two weeks on Medicare oral health coverage
- The top line budget numbers from the Senate Budget Committee include Medicare oral health coverage as a top priority.
- There are no details about the contours of the benefit known as of yet and it is not likely to come together for a while yet – perhaps when they come back from August recess to work on a reconciliation package.

- The key takeaway is that this is very much on the table in this enormous legislative package and a there remain a lot of policies and competing priorities at play.
- There is a clear commitment to oral health as well as vision and hearing, but it may depend on the funds available
- The committees of jurisdiction will get their instructions for working on this package and that's where the details will be debated
- The earliest timing of a vote would be end of September but more likely in October.
- We have a lot of momentum for the issue – including a lot of voter traction as indicated in polls. Real bipartisan support is influencing the conversation
- Individual oral health champions in Congress are keeping the issue front and center
- Things look good but there are many moving pieces and many details to be worked out
- August recess will be an important time for folks to make their voices heard…especially given staff will be working during the recess.

B. Collective Action

Laurie Norris presented….

About a week ago there was a request sent out from the Medicare + Medicaid Working Team inviting your organization to sign on to a letter in support of adding a dental benefit to Medicare Part B.

Laurie commented that we're doing this as a group to demonstrate that there is broad support for adding this benefit to Medicare and covered the main points in the letter.

Mike added that this is a time to keep this issue front and center and emphasize the importance of the dental benefit being part of Medicare Part B, not a separate section. And he urged as many PRW members as possible to sign on to the letter to demonstrate support and unity around this important matter.

Ann Battrell added that about 850 dental hygienists have participated in an online advocacy effort for this Congressional action.

C. Discussion

Some discussion ensued about who ought to be encouraged to sign onto the letter.

- Morally, this is the right thing to do to add this benefit to Medicare; however, the other side of this is that exactly how the benefit would be implemented is also important. And without knowing those details, which are very important, it's hard to know if the fee guidelines would be workable for providers because the fee structure is overall controlled by the government. I don't know if this is correct or not, but I am concerned about it.

(Melissa responded) A couple of things to think about here. Most of this would be worked out administratively not legislatively. And it will take 3-5 years to work out the details once the legislation passes. The statute won't determine any of the fee or payment structures.

(Mike Monopoli responded) It is important that the specifics are not in the statute and the implementation is definitely a "devil is in the details" situation. But we can't even get to that until the legislation passes.

- Only 71% of dentists support this because of the uncertainties around funding and administration. The concern is that the benefit will be funded by the providers. It is certainly inhumane that elders do not have access to dental care…but we need to know where the funding will come from.
- This would include persons with disabilities as well.
- It is in the nature of coalitions like this that they are challenged in situations like this. It's not about political parties; it's a function of who is taking the risk. We do need to get to the next step, as said, before we can work out the details. We really cannot let this moment pass.

(Melissa responded) I appreciate all of this and the politicians share these concerns. They only want to do that if it's going to work for providers and patients alike.

Laurie suggested that an added sentence to the letter might help folks sign on – a sentence about adequate reimbursement rates and input from the provider community…

From the Chat

- *(Myechia Jordan)* I completely agree with Steve. We have got to be united in advocating for this and then claim our seat at the table regarding reimbursement.
- *(Gary Pickard)* Agreed, and well said Steve. We may never have this opportunity again. We're so close. Our elderly and disabled deserve a dental benefit.
- *(MA Cordero)* THANK YOU LAURIE FOR THAT LAST STATEMENT.
- *(Laurie Norris)* Absolutely! We will send a revised letter out tomorrow for your consideration. We all agree that reimbursement rates must be adequate.
- *(Robert Zena)* A major concern with the potential addition of dentistry to the Medicare system is: will the free marketplace be ended as it exists now? In other words, will the fee schedules be universal for all dentistry regardless of whether you participate or not?

IV. Dental Benefits in Medicaid

Pat introduced Marko Vujicic and Colin Reusch to speak to another one of the Pandemic Response Workgroup's priorities: comprehensive Medicaid dental coverage. The work Marko and his staff have done in several states has been very helpful in getting the benefit approved.

A. Making the Case for Dental Coverage for Adults in All State Medicaid Programs

Marko moved through several slides fairly quickly from the full presentation: "Making the Case for Dental Coverage for Adults in All State Medicaid Programs" and emphasized these points:

- We've been making the case for an adult benefit in Medicaid, but in a slightly different way.
- The fiscal estimate is what's new in this paper, and it brings the whole thing together on one storyline and puts numbers behind what it would take to provide the benefit in the states that don't currently have comprehensive dental coverage for adults in their Medicaid programs. It looks at fiscal offsets in healthcare costs but does not look specifically at the economic return.
- This "Financial Barriers to Dental Care" chart is important in how it graphs the barriers to dental care by income and age group and shows how it is low-income working age adults who have the greater difficulty accessing dental care. This is not new information; it's just put in one place.
- The summary table is "What Would it Cost to Provide Extensive Dental Coverage?" In the 28 states that don't have coverage we estimate it would cost collectively about $1b/year on dental care and realize about $273m in medical care cost savings for a net price tag of $835m/year spread across 28 states.

There is a great deal more information in the full white paper. The price tag reflects rounding errors in health care. This puts some people at ease to see this. One reason the price tag is so reasonable is because we know that 100% of the beneficiaries will not take advantage of this benefit. In the states that do have comprehensive Medicaid coverage, we see only about 28% of those eligible taking advantage of it, spending on average $437 each.

From the Chat:

- *(Teresa (Terri) Dolan*) Marko - do these estimates include administrative cost?
- *(Colin Reusch)* They do not
- (*Colin Reusch)* Webinar on the paper here: https://www.youtube.com/watch?v=SFqN7wvCyKg&t=827s

B. Policy Options – Moving from Optional to Essential

Colin Reusch joined the conversation and suggested folks look at the details in the appendices of the paper to understand the state vs. federal breakdown and state-by-state breakdown.

- Most of the cost would be covered by the federal government, and these estimates are super conservative in terms of cost savings. Much of the cost savings are not included (e.g., from avoided emergency department visits).

- The per enrollee per month costs are very powerful. The net costs are $4.5/person/month. The state funds portion of that would be $1.50/person/month. It's really nothing.

This paper looked at the 28 states that don't currently offer the comprehensive dental benefit. This is what it would take to get to consistent coverage across the country, rather than access being dependent on where someone lives.

- Make comprehensive adult oral health coverage a permanent part of the Medicaid program for all states. Congress could designate dental services as a mandatory benefit category for all Medicaid-enrolled adults.
- Congress could consider policy aimed at establishing a baseline of comprehensiveness for adult dental services in Medicaid. Policymakers can amend the current statutory definition of Medicaid dental services to address the full range of oral health conditions, specifying categories of services as necessary.
- Congress could consider increasing the FMAP for states to support comprehensive oral health coverage. Adequate funding of state Medicaid programs is necessary for the successful implementation of a new benefit.
- Ensure that fiscal estimates (or CBO scoring) properly account for potential medical care cost reductions, including reduced emergency room spending, associated with expanded dental coverage for adults in Medicaid programs.

C. Questions/Comments

- The word "extensive" might be misleading – might be worth detailing those out. Are there specific categories of care and details re: financial coverage?

(Marko responded) There is no agreed upon definition. There are several out there. "Comprehensive/Extensive is detailed here on the landscape slide.

Source: Health Policy Institute analysis of data from Center for Health Care Strategies, Inc.[18] Authors have updated the analysis with data as of early 2021. **Note:** None = No coverage. Emergency-only = Coverage for pain relief under defined emergency situations. Limited = Coverage for a subset of diagnostic, preventive, and minor restorative procedures with a per-enrollee annual maximum expenditure of $1,000 or less. Extensive = Coverage for a more comprehensive mix of services, including at least 100 diagnostic, preventive, and restorative procedures, and a per-enrollee annual maximum expenditure of at least $1,000.

In the paper, we also call for a re-envisioning of coverage. It's all very arbitrary. There is an opportunity here to prioritize what it takes to be fully functional, without limitations around eating, speaking, smiling, ability to go to a job interview without concerns, etc. This is easy to say but difficult to write into regulation. But this is an opportunity to imagine what it should be.

- There were two plans submitted to the CBO three years ago that identify functional and more framed coverage, including a dollar cap, and they suggested a supplemental plan for people with noncommunicable diseases for more extensive periodontal care. The

questions of where we start, what's covered, how we quantify and measure and monitor it so dentistry has the data that's needed. Savings have been shown to be significant. The issue is being looked at universally and by population segments. The various groups working in this space ought to collaborate to develop the offerings that can engage the full community in supporting this- including those in the profession. We need a framework to detail what will be expected.

D. Collective Action

Colin spoke about the collective action letter that has been prepared by Community Catalyst and Pat shared the letter.

- The Medicaid Dental Benefit Act has been introduced and would accomplish many of the things I reviewed on that last slide.
- The letter makes the case for the benefit consistent with what Marko presented. It's a statement of support for the bill.

From the Chat:

- *(Colin Reusch)* Definition of services in bill: At a minimum, this bill would require state Medicaid programs to provide coverage to prevent and treat disease, promote oral health, restore oral structures to health and function, reduce pain, and treat emergency conditions. This coverage would include:
    - routine diagnostic and preventive care including but not limited to dental cleanings, exams, prophylaxis, fluoride treatments, X-rays, and other necessary services;
    - basic dental services such as fillings and extractions and major dental services such as root canals, crowns, restorations, and both complete and partial dentures including adjustments, repairs, and relines;
    - emergency dental care;
    - Temporomandibular (TMD) and orofacial pain disorder treatment;
    - other necessary services related to dental and oral health (as defined by the U.S. Secretary of Health and Human Services.)
- *(Colin Reusch*) Info on Medicaid Dental Benefit Act: https://barragan.house.gov/barragan-introduces-medicaid-dental-benefit-act/
- *(Emmet Scott*) Agree, when the benefit comes and goes it also makes it very difficult for dentists to feel confident to build a model to support patients with this insurance type. There is so much that goes into compliance and billing processes that if it's here today and gone tomorrow it is difficult to make those investments into infrastructure to properly accept that insurance.
- *(Colin Reusch)* Yes, very much agree that stability of coverage is an issue for both patients and providers. Link to sign on form & letter: https://forms.gle/nc3BFmkEgM9FX33y8

Pat Finnerty added:
When this benefit is mandatory, CMS takes a more active role in ensuring that states are doing what they need to do to make sure the benefit is available to people, that there are adequate quality measures, and more. It really makes it a far more impactful benefit with greater monitoring such that states pay attention to it.

V. Surgeon General's Report

A. Opening Remarks

Admiral Ricks clarified that as a federal employee he was obligated to stay out of the preliminary discussions related to the report.

The following are highlights from Mike Monopoli's remarks:

- We had a robust discussion last time around the Surgeon General's Report. We've been waiting for the twenty-year update to discuss progress and what is still to do since that report, which was the first such report on oral health.
- It became clear during in the transition between administrations that the new Surgeon General would not be releasing the report; rather NIDCR would be releasing the report as **Oral Health in America**, a research report.
- There was pushback from a lot of stakeholders about the importance of it being a Surgeon General's Report, which has international import and cross-sector impact much more than a research report.
- We had a discussion and agreed that we wanted to push back and advocate with the Surgeon General that he should release it as a Surgeon General's Report. I wrote a letter and shared it with Admiral Ricks' Public Private Working Group and sent it to everyone including federal employees which created a bit of a kerfuffle.
- There was no response from the Surgeon General's office, but I definitely did hear from NIDCR, prompting a clarification of my intention. I posted an update that my intention was to respond to the SG and not to downgrade the importance of NIDCR and we are now in a good place with NIDCR. We support their role in saving the report.
- Where we are now is that we need to think about how we can advocate together – if we should or should not – to keep things moving.
- NIDCR is going through the approval process…but I do think if we continue to advocate in this way, at least the Surgeon General may strongly support the report and advocate for oral health in other ways.

From the Chat:
(Gary Pickard) Good job Mike, sometimes we must poke the bear. Dentistry is critical and deserves being defended and considered a priority within the healthcare space.

Admiral Ricks added these comments.

- NIDCR did save the report. And this is not unprecedented; there are often reports commissioned by one Surgeon General that do not make it to press.

- We should not deduce that the Surgeon General does not value oral health; his senior advisor is an oral health person.
- He's been in office just a few months and right away was faced with the migration of unaccompanied children into the country, and the COVID crisis as well. Both have been top priorities.
- He wanted specifics in the report that would have delayed it by several years, and NIDCR saw the value of getting the information out while it was still timely, before the oral health data would become irrelevant.
- The report will be published in its entirety in the fall of 2021. It is now in production. They are merging texts and graphics.
- There are over 400 contributors to the report and NIDCR has emphasized the value of those contributions.
- They have done a Q&A and they have a robust communications plan, with plans to publish excerpts internationally, and the Surgeon General may participate in editorials and so forth.
- We need to stop calling it a Surgeon General's Report and call it Oral Health in America: Advances and Challenges, which is its title. This does not mean you should not stop advocating for the report; all of you will be key in disseminating the messages in the report.

B. Discussion re: Next Steps

What thoughts or ideas do you have to move this in the right direction? How can we make sure this document gets the visibility it deserves?

Summary of comments:

- Admiral Ricks clarified that the full report is being published, just with the NIDCR logo rather than the Surgeon General's. And that it is in production – merging graphics with text. There is an email provided to which you can send concerns and comments. oralhealthreport@nih.gov. Until it's published it's not a done deal.
- Manuel underscored the importance of the message getting out and the public being aware of all the things we are addressing.
- Ife asked if an NIDCR report is sent to Congress. Admiral Ricks said typically it is not; however, this is the kind of comment that can be sent to the email, and he will ask Dr. DeSouza if this is part of the plan. Ife added that it would be good timing with the legislation that is being proposed and considered.
- Myechia Jordan commented in the chat: *Distribution is key! We have to ensure that key stakeholders become aware of the existence of the report given it will not have the platform of the Surgeon General*
- Ife asked if the report would be out by October and Admiral Ricks responded that this is not known. They are aware of the big meetings coming up but will only say Fall 2021.
- Admiral Ricks chatted this quote: *NIDCR will encourage our stakeholders to further distribute the report to maximize the impact of the findings.*

- Mike added that this is the time to make these comments and recommendations to make sure the report is as widely accessible as possible.

From the Chat:

- *(RADM Tim Ricks*) Here is how NIDCR answers the communications question: "NIH has a vast communications network that has the power to reach millions of people. When the report is published later this year, NIH will issue a press release that will be distributed to thousands of mainstream reporters around the world. As part of the communications plan, the news release will be distributed through HHS's vast social media network, instantly reaching hundreds of millions of stakeholders. The report itself will be indexed for MEDLINE searches and posted to NIDCR's website for viewing and downloading. The report will be promoted via press interviews, webinars, conference presentations, and social media. Finally, every major public health organization focused on oral health will be notified of the report's release."
- *(Emmet Scott)* Need to jump into another meeting but love the work happening here and expansion of service and care. Appreciated the feedback from Dr Zena and Dr Cordero on the Medicare clarity. Look forward to having more conversation and support to have our groups sign on. Happy to have more conversations offline as appropriate to help support: escott@cdp.dental or 940.222.1610

VI. Biden Administration and Congressional Updates

Marcia Brand presented.

A. House Appropriations Committee Passed the Labor, HHS, Education and Related Agencies – Appropriations Bill 2022

- Passed by vote of 32-25.
- Proposed funding levels are expected to change, as both chambers of Congress are expected to engage in negotiations before the expiration of the current FY 2021 funding in September 2021.
- Bill is considered "high water mark" for funding, compared to what Senate is expected to propose.
- Congress reinstated Community Project Funding – members of Congress can request specific funding for projects in their jurisdiction; ($367,415,000); construction, renovation, equipment, other activities supporting health-related activities; two focus on oral health; list is alphabetical! E:\HR\OC\D375A.XXX (house.gov)

B. Oral Health in the House Labor HHS Appropriations Bill - Health Resources and Services Administration (HRSA)

- Oral Health Training - $42,673,000 ($2 million above FY 2021 enacted); includes $14 million for Pediatric Dentistry Programs, an increase of $2 million above FY 2021. Provides language about program continuations and grant cycles for programs funded through this line.

- Area Health Education Centers – Encourages HRSA to support AHEC oral health projects that establish primary points of services and address the need to help patients find treatment outside of hospital ERs. Encourages HRSA to work with programs that have already been initiated by some State dental associations to refer ER patients to dental networks.
- State Oral Health Programs – Includes $250,000 to continue demonstration projects to increase the implementation of integrating oral health and primary care practice.
- MCH – Encourages HRSA to explore opportunities to facilitate linkages between the agency's Home Visiting Program and Community Dental Health Coordinators, where available.
    - Also, within MCH - SPRANS set aside for oral health - $5,250,000
- Encourages HRSA to work with Community Dental Health Coordinators that have already been initiated by dental organizations to provide dental education, community-based prevention, care coordination, and patient navigation to children and vulnerable families.
- Ryan White HIV AIDS Dental Services - $15,122,000
- Health Centers funding - $1.8 billion, an increase of $148 million, includes $45 million increase for school health centers.
- **HRSA Chief Dental Officer** – Language expressing concerns that HRSA's CDO has **not been functioning at an executive level authority,** resources and staff to oversee oral health program have not been delegated, despite earlier Report language directing HRSA to do so.
- **Action for Oral Health** – (Enactment of) the Action for Dental Health Act of 2018 encourages HRSA to **expand oral health grants for innovative programs** under PHS Section 340G. The Act helps reduce barriers to dental care through oral health education, prevention, and the establishment of dental homes for underserved populations.
- **Oral Health Literacy** – Includes $500,000 to continue the development of an oral health awareness and education campaign across HRSA divisions, including workforce, MCH, Ryan White, Rural Health. Focus on oral health literacy.
- **Language that is NOT in the House Appropriations bill** – The Committee **strikes language** prohibiting HRSA funds from being used to support alternative dental providers (Title VII, 340G).
    - Notes that **dental therapists** are licensed providers who play a role in dentistry similar to the role that physician assistants play in medicine, and work under supervision.
    - Notes that ending the prohibition **will give States flexibility to expand the oral health workforce and improve access** to dental care, particularly in rural and underserved communities.

C. Oral Health in the Labor HHS Appropriations Bill – Other HHS Agencies

- CDC

- Includes an **increase of $2,000,000** to expand State and Territorial health departments (CDC oral health program) in their efforts to reduce oral disease and improve oral health through effective interventions (up from $19.5 million)
- Full funding would require approximately **$67 million**

- NIH - National Institute of Dental and Craniofacial Research
  - Appropriation - FY 2021 enacted - $484,667,000; Committee Recommendation - **$519,010,000; +$34,143,00 over enacted**
  - Encourages NIDCR to conduct additional research on **durable mercury-free dental restorative materials**
  - Includes an increase of $18,000,000 for NIDCR to **support research related to opioids, pain, and pain management** (in this line)
  - Notes appreciation to NIDCR for **leadership on the upcoming report** on "Oral Health in America: Advances and Challenges" and anticipates release of report
- CMS
  - Pleased that CMS is moving to fill the **Chief Dental Officer** position (vacant since October 2017).
  - Committee notes that **States have flexibility to determined dental benefits for adult Medicaid enrollees** and while most States provide at least emergency dental services for adults, less than half currently provide comprehensive dental care.
  - Urges CMS to provide **recommendations** no later than one year after the enactment of this Act regarding policies to increase the coverage of, and access to, comprehensive dental benefits for adults in State Medicaid programs.
  - Urges the CDO to examine opportunities within existing statutory authority to **expand Medicare** coverage of dental services.

D. White House COVID Task Force/Fifth Meeting, June 25

- Led by Chair Dr. Marcella Nunez-Smith
- Purpose of the meeting – consider interim recommendations addressing the **inequities and the impact of long-COVID** or Post-Acute Sequelae of SARS Co-V-2 infection, and **access to personal protective equipment, testing and therapeutics**.
- People living with long COVID symptoms have "felt alone" in their suffering, without recognition from the medical community or sufficient access to assistance programs.
  - Presentations by Dr. Bruce Siegal, President and CEO of America's Essential Hospitals, and Dr. Margot Gage Vitvliet, social epidemiology professor living with long-COVID
  - Recommendations related to long-COVID include:
    - **Creating more inclusive disability policies** that recognize long-COVID as a health condition, irrespective of whether individuals receive a positive test for acute COVID infection, for which they were or were not hospitalized.
    - Creating a **national coordination of research standards** and a standardized method to disseminate research, diagnostic, and therapeutic practices related to long-COVID.

        - Executing a robust, national communication and education to **build awareness**, educate and solicit data from the public **about long-COVID**.
    - **Additional recommendations**:
        - Maintaining an **adequate national stockpile** and creating a rapid emergency **production plan** for PPE for healthcare providers and all essential workers.
        - Creating **data transparency** related to the demographics of those receiving therapeutics and providing public health intervention funding to address barriers to care.

E. Biden Administration HHS Appointments, New Staff

- **Meena Seshamani, M.D., Ph.D., Deputy Administrator and Director of the Center for Medicare**
    - Will lead Center's efforts in serving people 65 or older, people with disabilities and people with End-Stage Renal Disease that rely on Medicare coverage.
    - Recently served as Vice President of Clinical Care Transformation at MedStar Health and as Assistant Professor of Otolaryngology-Head and Neck Surgery at Georgetown University School of Medicine.
    - Was director of the Office of Health Reform at HHS, leading the implementation of the ACA.
- **Perrie Briskin, Policy Advisor, CMS**; was serving as Senior Advisor to HHS COS from 2/21 – 7/21, served in leadership roles on Biden's health policy and transition teams.
- **Dr. Dora Hughes, Policy Advisor, CMMI, CMS** (not a political appointment) – leaves CareQuest, continues at GWU as faculty.

VII. COVID 19 Updates

Mike Monopoli presented.

- To date, the total number of COVID-19 cases in the US are 34M and 191M in the world. There have been 608,000 deaths in the US and 4M in the world.
- 13% of people in the world are fully vaccinated; 49% in the US = 161M people are fully vaccinated
- Vaccination rates are down, and we need to continue to address the issues that are keeping people from being vaccinated.
- The Delta variant is highly communicable – 83% of cases in the US are now from the Delta variant. It's highly communicable and the vaccines are effective.
- There has been some questioning of the efficacy of the Johnson + Johnson vaccine against the Delta variant; however, it is said it is effective, but some physicians are suggesting an MRNA booster.
- There is a lot of focus now on Delta and issues with breakthrough infection being played up by the media, but we need to keep it in context. There are only 5,000 cases among the millions vaccinated; there have been 80 deaths but it's .008% of those fully vaccinated.
- We still have an important role in working to get good information out to people and fight against misinformation.
- A lot of the media has to do with the single dose vaccine is the most relevant to the oral health provider community so we'll need to follow this and see how it plays out in terms of our role as vaccinators.
- We are continuing to advocate for the Medicaid and private plans to include the vaccination codes in reimbursement schedules.
- As the vaccination campaign is more individualized, it's important that dental providers continue to do their part around evidence-based understanding of COVID and the efficacy and safety of the vaccines and countering misinformation.
- There is the Delta variant and with so many people unvaccinated, there could be other variants, and promoting equitable access to vaccines continues to be an important role for dentists and hygienists to play.
- We've had good progress with dental and hygiene schools providing training around injections, continuing to make vaccinations part of the curriculum.
- There is a reassessment of infection control guidelines – the ADA and CDC are looking at this.
- At CareQuest we are focusing on spread through aerosols to understand the risks – we need a fuller understanding of risks and mitigation options so we can ensure providers and patients are safe in an oral health care environment.

VIII. Closing

Dr. Jordan shared some closing comments.

Thank you everyone for the engaged discussion today. I come away each time with appreciation for the power of this group – and today I especially appreciated understanding how we get to alignment. Clearly there are different perspectives in the group, which is the beauty of it, and there are places where we need to push forward and advocate so we need to understand the barriers to getting there. The candid conversation we had today is important and we need to have more of it…as we continue to align so we can advocate for equitable oral health access for all Americans. Thank you for your ongoing commitment to these discussions, for your candor today, and recognize how powerful it is when we can get behind these advocacy topics in pursuit of our mission, which is to ensure that everyone has equitable access to oral health.

Pat reminded folks as follows:

- Let us know if you or your organization wants to sign on to the Medicare letter and/or the FUSA/CC Medicaid letter
- We will not be meeting in August. Our next meeting date is September 15th.
- When we return in the fall, we're planning on hearing updates, proposals, and opportunities for action from each of the Working Teams as well as discussing oral health workforce diversity.
- If you have any thoughts on these topics or have any other suggested topics for us to address, please send Mike an email by mid-August so we can build that into our meeting planning process.

From the Chat:
(Myechia Jordan) And if you don't agree to signing on, how can we get you there? Alignment is key!