Testimony for the Senate Majority Policy Committee Hearing on Rural Dental Care

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Chairman Argall and members of the committee,

Thank you for the opportunity to speak with you today. My name is Helen Hawkey, and I am the Executive Director of the Pennsylvania Coalition for Oral Health (PCOH), a statewide advocacy organization committed to advancing access to oral health services for all Pennsylvanians. PCOH also serves as the sole contractor for the PA Department of Health Oral Health Program and helps to implement the goals of our state's oral health plan. I also have the honor of serving as the incoming chair of the Pennsylvania Rural Health Association (PRHA) board of directors, which works to elevate the health and well-being of rural communities across the commonwealth.

My personal background includes working in clinical dental practice as a dental hygienist, serving as an officer with the state dental hygiene association, working in pediatric dental research at the University of Pittsburgh, and operating a small consulting business where I provided continuing education to medical and dental providers, community groups, parents, and childcare workers.

I appreciate your attention today on an issue that profoundly impacts rural families across Pennsylvania: the urgent and growing lack of access to dental care in rural communities.

PA Providers

Pennsylvania's dental workforce is made up of several professional roles, each playing a unique part in delivering care. Dentists (DMDs or DDSs) are the primary providers of diagnostic, restorative, and surgical dental services. Dental hygienists focus on preventive care, including cleanings, sealants, and oral health education. Some hygienists in PA obtain an additional certification to become public health dental hygiene practitioners (PHDHPs), allowing them to provide preventive services in community-based settings without direct supervision by a dentist—an especially valuable model in rural and underserved areas. Dental assistants, who may be certified or registered with their national association but are not recognized in Pennsylvania with a formal certification, support dentists and hygienists in clinical procedures and patient care. For the last 15 years, Pennsylvania has also included the use of expanded function dental assistants (EFDAs), who are trained to place fillings and perform other technical tasks under direct supervision of a dentist. Each role plays a vital part in expanding access, especially when leveraged creatively in schools, community health centers, and through teledentistry platforms. Strengthening and supporting this full spectrum of the dental team is essential to improving access in Pennsylvania's rural communities.

2023 Pennsylvania Dentist and Dental Hygienist Workforce Survey Report

- Dentists – 9,002 – At first glance, this appears to be enough – 1 dentist per 1,400 people, far better than the 5,000:1 ratio required to be designated a dental health provider shortage area. When we look at those actively seeing patients in Pennsylvania, this list drops to just over 6,500. This is evidenced by the data captured in the 2023 Department of Health Dentist and Dental Hygienist Workforce Survey Report. In 2023, only 17.9% of dentists provided direct patient care in rural counties in Pennsylvania, substantially lower than 82.1% of dentists in urban counties. One national statistic that we use for comparison is the ratio of dentists providing direct patient care per 100,000 population. The commonly accepted preferred ratio for that is 60

dentists per 100,000 people. In 2023, it was 56.1 in urban counties in Pennsylvania in 2023, but just 34.9 in rural counties. Lastly, nearly 25% of our Pennsylvania dentists are at least 65 years old, which means a quarter of our dentists could retire tomorrow.

- Registered Dental Hygienist – 8,752 - Our hygienist numbers continue to decline in close alignment to our dentists. Looking at the same workforce report I mentioned just a bit ago, we know that only three-quarters (76%) of these positions are providing direct patient care. RDHs do tend to work in rural areas in higher numbers than dentists do, 23% compared to 19%. Ideally, a well-functioning dental office that is providing proper preventive care to healthy dental patients would need two hygienists for every dentist, a 2:1 ratio. We currently have an almost exact 1:1 ratio, which means we need to double the amount of dental hygienists in the state.

- PHDHPs – 703 certified out of the hygienists providing direct patient care – This number has grown exponentially since the position was first introduced in 2010. A variety of practice opportunities are available for those who want to work in public health, though the barriers of starting a healthcare business for patients who are largely unable to pay is burdensome. PHDHPs are permitted to be credentialed as Medicaid providers through Medicaid managed care organizations, but only about 150 of them have completed that process.

- EFDAs – 2,649 – This is a heavily underutilized model in PA – this position can be used as a sort of 'dentist extender'. EFDAs can place fillings once the tooth is prepared, which can free up the dentist to treat more patients. An ideal office would employ 1-2 EFDAs per dentist, but there are only enough for less than half of the dentists in the state to employ one.

Oral Health and Systemic Health

Oral health is inextricably linked to overall health. Untreated cavities and gum disease don't just cause pain and tooth loss, they're associated with serious systemic conditions like diabetes, heart disease, strokes, and adverse pregnancy outcomes including preterm birth. In children, dental problems are a leading cause of missed school days and can impact nutrition, speech, sleep, self-esteem, and early development. For older adults, poor oral health complicates the management of chronic illnesses and leads to avoidable emergency department visits and hospitalizations. Oral infections, especially in rural areas where access is limited, too often become medical emergencies that are three times more costly compared to the cost of treatment in a dental office.

Despite this, dental care remains siloed from the rest of the healthcare system. Integrating oral health into primary care, public health, and behavioral health settings is not only good practice, but it's good policy, particularly in rural communities where providers must work across disciplines to meet the needs of patients. The Medical Expenditure Panel Survey (MEPS) tracks the individuals who seek medical and dental care across the country. In 2022 in Pennsylvania, 17% of our residents did not have either a medical or dental visit, but 33% of them did have a medical visit without a dental one. Embedding dental providers in a rural medical office is an opportunity to add oral health services and reach a large part of the population who wouldn't get dental care otherwise.

The HR68 Report: A Clear Call to Action

In January 2023, the General Assembly's Legislative Budget and Finance Committee published the findings of its HR68 study, which examined rural dental health disparities in Pennsylvania. The 116-page report represents one of the most comprehensive reviews of rural dental access challenges our state has ever completed. Its conclusions were sobering but also provided a clear roadmap for how we can act.

Some of the key findings include:

- **27 of Pennsylvania's 30 rural counties (90%) have a dental health professional shortage area designation.**
- **11 rural counties had fewer than 10 licensed dentists total**, some as few as 1 or 2.
- A significant number of rural counties, such as **Forest, Potter, Juniata, and Cameron**, were identified as having **no dentists actively billing Medicaid**.
- **Only 23% of active dentists in Pennsylvania accept Medical Assistance**, and **less than 10% see a significant number of Medicaid patients** annually. Residents of rural counties have nearly 40% more Medicaid members per dentist than their non-rural counterparts.
- When assessing the geographic distribution of dentists based on the number and location of dental offices and adjusting for population, the number of providers in non-rural counties outpaced those in rural areas at a ratio of 15:1.

These statistics reflect structural inequity. Families in rural Pennsylvania are far more likely to suffer tooth loss, miss school or work due to oral pain, or delay care until problems become emergencies—all because care is out of reach.

A Shrinking Workforce and Growing Need

The HR68 report also highlights a concerning trend in the dental workforce:

- **40% of practicing dentists in Pennsylvania are over the age of 55**, and many are nearing retirement.
- Rural areas face **greater difficulty recruiting and retaining younger dentists**, particularly due to financial disincentives, professional isolation, and lack of mentorship or support.
- The existing dental school pipeline is inadequate for rural needs. **Of the approximate 350 dental school graduates who enter the field each year, only 5%** of dental students in Pennsylvania report intentions to practice in a rural area.

This leaves rural communities facing a worsening cycle: as providers age out of the workforce, there are no new practitioners moving in to take their place.

Telehealth and Teledentistry: A Solution That Needs Support

The HR68 report recommends expanding teledentistry, noting its strong potential to bridge gaps in areas with no available dental providers. A 2022 report from our organization found that the average wait time for a dental appointment across the state is now 55 days, a significant growth over the 14 days it took just five years ago.

Teledentistry can:

- Enable rural residents to access consultations, education, and referrals without traveling long distances;
- Allow dental hygienists and school nurses to collect diagnostic data and transmit it to offsite dentists;
- Help manage chronic dental conditions through non-surgical care and prevent unnecessary emergency room visits.

Yet despite its promise, Pennsylvania lacks a comprehensive framework to implement and reimburse for teledentistry. We are all familiar with the broadband issues in rural areas which make this a big issue. There is also a

lack of knowledge by patients and dental providers about the care that can be offered via teledentistry and the models that could be followed to reach the most people. This is a missed opportunity.

Public Health Dental Hygiene Practitioners (PHDHPs): A Proven, Underused Workforce

The HR68 report also endorses the expansion of PHDHPs as a vital step toward improving rural dental access. Pennsylvania is one of about 40 states that allows dental hygienists to practice independently in public health settings, but current restrictions limit their reach.

Barriers include:

- Setting limitations—PHDHPs can only practice in specific approved locations (e.g., schools, Head Start programs, correctional facilities);
- Low Medicaid reimbursement rates, which make it difficult for community programs to financially sustain their services;
- Low numbers of providers with the certification.

The report recommends:

- Expanding settings where PHDHPs can practice;
- Increasing Medicaid reimbursement for preventive services delivered by PHDHPs;
- Supporting community health organizations and schools in establishing sustainable PHDHP service models.

This model is already working in practice. For example, PHDHPs working in school-based programs have been able to provide screenings, cleanings, fluoride varnish, and sealants to children who otherwise would not see a dental provider. In Pennsylvania, just 91 schools received services through Department of Health-recognized school sealant programs in the 2023-2024 school year.

Medicaid Participation and Payment Issues

Another critical barrier identified in the HR68 report is Medicaid dental participation and reimbursement:

- Many dentists cite low reimbursement rates and administrative burdens as reasons for not participating in the Medicaid program.
- Rural dentists also face the challenge of high overhead and thin margins, which make it difficult to absorb undercompensated care.

This is not simply a matter of provider choice, it is a policy design issue. Improving provider participation requires:

- Increasing Medicaid reimbursement to **at least 70–80% of commercial rates (Missouri has a proven model where this worked)**;
- Reducing administrative red tape for credentialing and claims submission;
- Offering provider incentives to treat Medicaid-enrolled children and adults in rural areas.

Without a financially viable model, we cannot expect private practices—or even federally qualified health centers—to fill this gap alone. Though we hear a lot about pop-up clinics like Mission of Mercy and Remote Area Medical sites,

I think we can all agree that standing in line all night to get a cavity filled or a tooth pulled in a sports arena is not an ideal or permanent solution to a worsening problem.

Economic Stability

A 2022 PCOH workforce report found that dental care sites produce economic development that creates jobs and accrue labor income that is spent in local communities. Labor income is a vital aspect to economies, especially for rural counties. Pennsylvania lost 216 rural dentists from 2015 to 2021. This corresponds to a loss of approximately $73M in labor income for rural counties and affects more than 1,000 jobs. Additionally, the state lost approximately $6.3M in annual tax revenue from dental workforce attrition through our 7-year study period.

What Can the Legislature Do?

Informed by the HR68 report and the experiences of our coalition members across rural Pennsylvania, we respectfully recommend the following legislative actions:

Create a Rural Dental Workforce Incentive Package

Establish loan repayment and tax credit programs for dental providers who commit to rural practice;
Offer dental hygiene and dental assisting programs in rural areas as students do not typically travel far to attend these schools and colleges;
Fund rural dental residency programs and externships to support student rotations in high-need areas.

Expand and Support PHDHPs

Amend statutes to allow PHDHPs to work in more community settings;
Increase Medicaid reimbursement for services provided by PHDHPs;
Provide startup funding for school-based and community-based PHDHP programs.

Advance Teledentistry Legislation and Medicaid Reimbursement

Develop Medicaid billing codes and payment policies for virtual dental assessments and case management;
Fund equipment and broadband access in rural schools and health clinics to support implementation.

Restore and Strengthen Medicaid Adult Dental Benefits

Ensure that preventive and restorative care are accessible to all adult Medicaid recipients;
Expand coverage to include root canals, crowns, and treatment for gum disease.

Establish a Rural Oral Health Task Force

Task with coordinating strategies across departments (Health, Human Services, Education, etc.);
Include rural providers, patients, and advocates;
Deliver annual recommendations to the General Assembly.

Conclusion

The HR68 report shows us the depth of the problem, but also points to viable, cost-effective, and community-supported solutions. The lack of dental access in rural Pennsylvania is not just a health issue, it's a workforce, economic, and equity issue. Oral health is essential to overall health, employability, and quality of life.

We cannot afford to let these disparities persist. But with targeted legislative action, investment in our workforce, and expanded use of technology and prevention, we can build a system where geography no longer determines health. Thank you for your attention and commitment to this issue. I welcome your questions, even at a later date as work progresses.