

**Testimony of
Dr. Brent Martin
Before
The Appropriations Committee
regarding the Department of Social Services Budget
February 18, 2009**

Senator Harp, Representative Geragosian, and members of the Appropriations Committee:

My name is Dr. Brent D Martin, and I am anxious to share with the committee my experiences and perspective, related the proposed elimination of necessary healthcare benefits for patients who realistically have no other choices available for their relief of pain, and preservation of health.

By way of background, I am an honors early graduate of dental school, I have seen over 100,000 patients during my clinical practice years. I also have an MBA in health care economics, and health care administration, and I have served in senior management positions for both AETNA and CIGNA, and responsible for oversight of thousands of dental offices and hundreds of thousands of patients. At this time I am extremely fortunate to work with Charter Oak Health Center as Sr VP of clinical Business Development.

ONE: Conceptual Flaws:

Relief of pain; the proposal suggests a 22 million dollar first year savings from elimination of adult Medicaid dental services, and I quote from page 519 "The department will continue to provide emergency dental services, including, dentures, x-rays, limited oral exams, emergency treatment of pain, and extractions."

I caution a thorough reading of this language in this proposal, as I have never encountered an "emergency denture", nor is their any such code provided by the ADA. The associate fee of over \$1000.00 would also pay for significant preventive and/or restorative care.

The implication inherent in the proposal is clear: oral health pathology for adults should either be extracted or ignored.

There is no debate among health care specialists; to the contrary there is unanimity of opinion that the patient has nowhere to go, and no choices available for them.

In fact the patient when in severe pain, or with fractured teeth, will most often present themselves to ER, and of course that is the most expensive and least efficient possible place to go,

This could be as simple as a healthy 21 year old, eating popcorn, fractures a tooth, with healthy normal bone., The patient is then be subject to extraction of that tooth and subsequent disfigurement

All which is unethical, and totally archaic compared to what we teach in dental schools.

And regarding the emergency room,
ER's cannot, fix it [there is no one in the ER to do it]
ER's do not [they provide a prescription to temporarily palliate the symptoms,]
and will not provide care; just a prescription or two which may or may not help for pain

Under the proposed future state, private practicing providers will also do everything possible to avoid adult patients because there would be no expectation of reimbursement.

How many of you would continue in your business or job, with no expectation of being paid ?

TWO: Forced/Required Quality of Treatment Disparities

If any of you have experienced dental pain, you can relate to the published science that indicates that dental pain, is always listed in the top 2 or 3 of most intense pain that patients encounter throughout their body. The relief of that pain, should **not** always be related to the extraction of the tooth, which is clearly the path the proposed plan forces the patient to follow. I think overwhelming professional opinion would consider this unethical, and likely mal practice by today's standards of care.

How about the adult pregnant patient who cannot seek dental care, and the literature is clear about drastic increase in low birth weight and premature babies in the presence of periodontal disease. Are we willing to accept that? Are we willing to pay for that ?

We all know that prevention of disease is cost effective, and the best possible process to follow, and the proposal eliminates essentially all prevention for adults.,

Costs will only increase. Patients who have lost their natural teeth have dramatically more hospitalizations for GI diagnosis than those that have natural teeth because dentures do not prepare the food as well for digestion.

I will share a personal experience regarding a patient that I treated a few years ago in an office I owned. The patient presented sweating, and telling the receptionist he had not slept for two days, he had been to an emergency room because of intense pain, and he wanted his tooth removed. I was called in to meet him, and he told me,

“ I served two tours in Vietnam, and I have been shot twice, and nothing has hurt like this tooth ache, and I WANT IT OUT”

I told him no you don't, what you want is to be free of pain, and removal of that is not the best answer, because replacement, or even not replacing it in this area or the mouth will lead to much more expense.

A leading cardiologist at ST Francis called me one night and explained of his extreme pain, and told me that nothing he did in the area of invasive cardiology and treating patients ever hurts like this”

The solution was NOT removal of the causative factor *for him*, and I would ask why should adult Medicaid patients be delegated to lesser quality treatment than anyone else?

THREE: Business Flaws

Science based; Literature is replete with increasing evidence of the direct linkage between disease in the oral cavity and overall health status of the patients.

Specifically I would reference the committee to research by Dr Dominique Michaud of the Imperial College of London and colleagues who wrote in the journal Lancet Oncology

They wanted to understand the relationship between gum disease and risk of cancer.

“Those with a history of gum disease had a 36 percent higher risk of lung cancer, a 49 percent higher risk of kidney cancer, and a 54 percent higher risk of pancreatic cancer, and finally a 30 percent higher risk of having a blood cancer.

And so eliminating the preventive procedures that would control gum disease makes sense how ?

Clearly, *encouraging an increase in disease* and knowingly allowing or encouraging MEDICAL expense to dramatically grow and thereby require more taxpayer funds seems at best inappropriate strategy.

We also know the extraction of teeth on adults, especially in those areas that show in public, dramatically influences the "hireability" of applicants. Literature reviews all indicate that the hiring decision is dramatically different when front teeth are missing, even in entry level jobs, so forcing the removal of the patients teeth, clearly alters their ability to be hired in a very high percentage of jobs.

Obviously that is not the best answer for the long term recovery of our economic crisis in Connecticut.

Finally, my three minutes are up; I would leave you with a thought that there is another way to achieve savings that would require a team to focus on a different approach, that would essentially allow a maximum allowance per adult Medicaid patient (like the calendar max you probably have in your commercial insurance policy) that would give patient choices and deliver better overall health.

For your awareness, my alternative proposal would be to take top line actual budget expenditures times required discount to achieve savings, eliminate crown and bridge coverage to determine dollars available. Then take the eligible pool of patients times the historical utilization factor to understand the total expected number of patients who will receive treatment.

Then simple arithmetic will tell us the maximum allowable expense per patient without forcing patients to become dental cripples, crowd our emergency rooms, while we knowingly and with intent forced them to receive sub standard care

Thank you for your thoughtful consideration of my comments, I would share that I am very aware of the difficulty of the task you face; however if relieving human suffering and enabling the best long term health care is not our most important responsibility, what is ?