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EVALUATING PEDIATRIC DENTAL CARE UNDER MEDICAID

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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EVALUATING PEDIATRIC DENTAL CARE UNDER MEDICAID

WEDNESDAY, MAY 2, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON DOMESTIC POLICY,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:05 p.m. in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Waxman, Cummings, Watson, Davis of Illinois, Issa, and Shays.

Also present: Representatives Towns, Sarbanes, and Wynn.

Staff present: Jaron R. Bourke, staff director; Noura Erakat, counsel; Jean Gosa, clerk; Auke Mahar-Piersma, legislative director; Natalie Laber, press secretary, Office of Congressman Dennis J. Kucinich; Karen Lightfoot, communications director/senior policy advisor; Leneal Scott, information systems manager; Jacy Dardine, intern; Tim Westmoreland, health consultant; Andy Schneider, chief health counsel; Art Kellermann, health science fellow; Susie Schulte, minority senior professional staff member; and Alex Cooper, minority professional staff member.

Mr. KUCINICH. The subcommittee will come to order.

We are expecting a series of votes, but I think what we will try to do is at least get the opening statements in, and so I want to welcome our witnesses and welcome everyone in the audience to this hearing of the Domestic Policy Subcommittee of the Oversight and Government Reform Committee, to today's hearing, "Evaluating Pediatric Dental Care under Medicaid."

I want to thank our ranking member, Mr. Issa, for being here, and thank Mr. Cummings, who was instrumental in creating the circumstances which caused this committee to come forward and have a hearing.

Mr. Cummings, thank you once again for your help.

Good afternoon. This subcommittee has come to order, and today we are taking a closer look at the circumstances that led to the death of Deamonte Driver, a 12 year old Medicaid eligible boy who died of a brain infection caused by untreated tooth decay.

This hearing will focus on the adequacy of oversight of pediatric dental care and Medicaid.

In its 2000 report, Oral Health in America, U.S. Surgeon General David Satcher demonstrated that oral health is essential to general health. The mouth and its surrounding tissues provide protection against microbial infections and environmental germs, and they are

associated with detecting nutritional deficiencies and systemic diseases.

We have a series of slides here, and I will just proceed and will ask staff to just try to synchronize the slides with the text.

All oral diseases are progressive, cumulative, and consequential. Tooth decay often occurs in early childhood and is the most common childhood disease. It is five times as common as asthma and seven times as common as hay fever. This has the most detrimental impact on low-income communities. As the slide indicates, 80 percent of cavities occur in only 25 percent of children, predominantly low-income children. Low-income children suffer twice as much from tooth decay than do the more affluent children.

Medicaid is the largest source of health insurance for low-income children, providing care for one out of every four children. Despite the coverage provided by Medicaid, it has been unable to fill the gap of providing dental care to poor children.

In 1999, 26.12 percent of eligible children received any dental services, and by 2000 that number had risen to only about 34 percent, not many percentage points more than dental service utilization by uninsured children.

On Monday, the Center for Disease Control issued a new national study that found that tooth decay in baby teeth had increased among U.S. toddlers and pre-schoolers age 2 to 5. The CDC study also found that 74 percent of young children with cavities were in need of dental repair.

In late February we witnessed the most tragic consequences of untreated oral disease. On February 25th, 12 year old Deamonte Driver died of a brain infection caused by untreated tooth decay. By the time Deamonte received any care for his tooth, the abscess had spread to his brain, and after 6 weeks and two operations Deamonte died. Filling a cavity, performing a root canal, or extracting the tooth might have saved Deamonte's life, and yet the challenges in finding a dentist and ensuring care precluded that opportunity.

Deamonte's death demonstrates both the importance of oral health to children's welfare, as well as the sometimes fatal and often costly consequences of its inadequate success.

We will take a closer look at Medicaid in Deamonte's home State, Maryland. Using the Health Plan Employer Data and Information Set measures, they estimate that 45.8 percent of Medicaid eligible children age 4 to 20 and enrolled for 320 days received dental care in 2005. Using the CMS form 416 measure, which is slightly different, the Maryland utilization rate for 2005 is 30.7 percent.

Oversight by Government agencies is critical to ensuring that Medicaid serves the population as intended. But what is the quality of the data used in this oversight function? Consider this: one of the factors State regulators look at is the number of health care providers in the provider network. The managed care organizations providing the dental health services report this number to the Maryland Department of Health and Mental Hygiene. Now, according to Maryland, between 2005 and 2006 the number of dentists serving the Medicaid population in Prince George's County increased from 162 to 360 providers. In Deamonte Driver's case,

there were 24 dentists in all of Prince George's County, according to the directory published on the Web site of United Health Care.

In preparing for this hearing, I directed my staff to do a spot check of dentists listed in United Health Care's provider network. Of the 24 dentists that they called, 23 of the numbers were either disconnected, incorrect, or belonged to a dentist who does not take Medicaid patients. The 24th dentist did accept Medicaid patients, but only for oral surgery and not for general dentistry. Effectively, none of the 24 numbers listed would have been of any use to Deamonte Driver.

The regulators who use MCO-provided data would have believed that the number of dentists that could have served Deamonte was 24, because that is what United Health Care would have told them, but the real number is zero.

The case of Deamonte Driver raises a question we are considering in today's hearing: do the figures used by Government and for government oversight accurately reflect the accessibility and utilization of dental care?

We will also consider the role played by the Centers for Medicaid and State Operations [CMS]. The Federal Government provides half or more of Medicaid funding to every State. It is the function and responsibility of CMS to ensure that money is being spent effectively to provide dental care to Medicaid eligible children.

CMS uses the form 416 to ensure that children receive dental care as mandated by the Social Security Act. Although the form 416 is the only oversight mechanism used by CMS to ensure compliance with the act, not all States submit their form 416s annually. One of the witnesses today will testify even when the form 416s are submitted, the data may not be reliable or informative.

Form 416s do not tell us why utilization rates are low, how many children received adequate and appropriate care, how many of the children that received the screening received preventative or restorative care for that screening, how many dentists are providing the care for children, and they don't tell us whether or not a handful of benevolent dentists are providing the care that should be spread across a broad network of providers. All the form 416s tell us is how many children are enrolled in Medicaid, how many of them receive a screening, how many receive preventative care, and how many receive restorative care.

Our hearing will afford us the opportunity to ask how can we confirm that dental care and Medicaid is adequate if the only information available to us is either incomplete, unreliable, or both.

We know even less about Medicaid managed care organizations. Managed care organizations don't complete the form 416s. They only report to the States. All of the data the MCOs report is created by the MCOs, themselves. This is concerning, since 47 States and the District of Columbia enroll some or all of their Medicaid populations in managed care.

In 2004, managed care provided benefits for approximately 60 percent of Medicaid beneficiaries nationwide. How do numbers reported by Medicaid managed care organizations and overseen by Federal agencies reflect the reality of access to and availability of dental care? What do these statistics really mean? What do they

tell us about children's dental care? Do we know enough to prevent another tragedy like Deamonte's?

Medicaid's inability to provide adequate dental care to children has been known since at least 2000, when the U.S. Surgeon General published his report. At the time of the report's publication, Deamonte was only 5 years old.

A year later, on January 18, 2001, when Deamonte was 6 years old, the former Director of the Center for Medicaid and State Operations issued a Dear State Medicaid Director letter. These letters are often used by CMS to provide information, guidance, and direction regarding Medicaid policy. In that letter, the Director requested information on State efforts to ensure children's access to dental services under Medicaid.

The January 18, 2001, letter indicated that HCFA, presently known as CMS, would undertake intensive oversight of States whose dental utilization rates, as indicated on the HCFA 416 annual reports, were below 30 percent, including the site visits by the regional office staff. States between 30 and 50 percent would be subject to somewhat less stringent review.

This letter was written 6 years before Deamonte's tragic death, at a time when something could have been done to save him. Significantly, Maryland was among the 15 worst performers. In 2005, the date of the most recent documentation, Maryland had just climbed out of the lowest category.

That raises the question: would Deamonte's fate have been any different if CMS had subjected Maryland to a stringent review in 2001, as indicated by the January 18th letter? Was a critical opportunity lost to save a boy's life?

This is not a case of an unfortunate boy fallen through the cracks, since the majority of Medicaid eligible children do not receive dental care. Rather, it is a tragic consequence of a system that creates a captive population for managed care organizations and allows managed care organizations to report on themselves to Government regulators. This is a system that puts profit above people.

A little boy died for lack of a dentist. A dental screening would have only cost the managed care organization in which he was enrolled about $15. Taxpayers paid the managed care company about $4,800 over the course of the last 5 years of Deamonte's young life to provide him with a dentist and routine screenings that he obviously never received. The managed care company's parent retained about $12.5 billion in net profits during the same period.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

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CHAIRMAN,
SUBCOMMITTEE ON DOMESTIC POLICY

COMMITTEE ON OVERSIGHT AND
GOVERNMENT REFORM

COMMITTEE ON EDUCATION AND LABOR

Opening Statement
Congressman Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee

"Evaluating Pediatric Dental Care under Medicaid"
Wednesday, May 2, 2007 – 2:00 P.M.
2154 Rayburn HOB

Good afternoon and welcome. The Domestic Policy Subcommittee of the Oversight and Government Reform Committee will come to order.

Today we are taking a closer look at the circumstances that led to the death of Deamonte Driver, a twelve year-old Medicaid eligible boy who died of a brain infection caused by untreated tooth decay. This hearing will focus on the adequacy of oversight of pediatric dental care in Medicaid.

In his 2000 report, *Oral Health in America*, U.S. Surgeon General David Satcher demonstrated that oral health is essential to general health. The mouth and its surrounding tissues provide protection against microbial infections and environmental germs and they are associated with detecting nutritional deficiencies and systemic diseases.

[SLIDE 1: CDHP slide] All oral diseases are progressive, cumulative, and consequential. Tooth decay often occurs in early childhood and is the most common childhood disease. **[SLIDE 2: CDHP slide]** It is five times as common as asthma and seven times as common as hay fever. This has the most detrimental impact on low-income communities. **[SLIDE 3: CDHP slide]** As the slide indicates, eighty percent of cavities occur in only twenty-five percent of children—predominantly low-income children. Low-income children suffer twice as much from tooth decay than do more affluent children.

[SLIDE 4:CDHP slide] Medicaid is the largest source of health insurance for low-income children, providing care for one out of every four children. Despite the coverage provided by Medicaid, it has been unable to fill the gap of providing dental care to poor children. In 1999, 26.12% of eligible children received any dental services—by 2005, that number had only risen to about 34%--<u>not many percentage points more than dental service utilization by uninsured children</u>. **[SLIDE 5:CDHP slide]**

On Monday the Center for Disease Control issued a new national study that found that tooth decay in baby teeth had increased among U.S. toddlers and preschoolers aged 2-5 years old. The CDC study also found that 74% of young children with cavities were in need of dental repair.

In late February we witnessed the most tragic consequences of untreated oral disease. **[SLIDE 6: Washington Post article]** On February 25th, twelve-year-old Deamonte Driver died of a brain infection caused by untreated tooth decay. By the time Deamonte received any care for his tooth, the abscess had spread to his brain and after six weeks and two operations, Deamonte died. Filling a cavity, performing a root canal, or extracting the tooth might have saved Deamonte's life and yet the challenges in finding a dentist and ensuring care precluded that opportunity. Deamonte's death demonstrates both the importance of oral health to children's welfare as well as the sometimes fatal and often costly consequences of its inadequate access.

We will take a closer look at Medicaid in Deamonte's home state, Maryland. Using the Health Plan Employer Data and Information Set measures, they estimate that 45.8% of Medicaid eligible children aged 4-20 and enrolled for 320 days received dental care in CY 2005. Using the CMS Form 416 measure, which is slightly different, the Maryland utilization rate for 2005 is 30.7%.

Oversight by government agencies is critical to ensuring that Medicaid serves the population as intended. But what is the quality of the data used in this oversight function? Consider this: one of the factors state regulators look at is the number of health care providers in the provider network. The managed care organizations providing the dental services report this number to the Maryland's Department of Health and Mental Hygiene. According to Maryland, between 2005 and 2006 the number of dentists serving the Medicaid population in Prince George's County increased from 162 to 360 providers. In Deamonte Driver's case, there were 24 dentists in all of Prince George's County, according to the directory published on the website of United Health Care.

In preparing for this hearing I directed my staff to do a spot check of dentists listed in United Health Care's provider network. Of the twenty-four dentists that they called, twenty-three of the numbers were either disconnected, incorrect, or belonged to a dentist who does not take Medicaid patients. The 24th dentist did accept Medicaid patients but only for oral surgery and not general dentistry. Effectively, none of the twenty-four numbers listed would have been of any use to Deamonte.

The regulators, who use MCO-provided data, would have believed that the number of dentists that could have served Deamonte was 24, because that's what United Health Care would have told them. But the real number is "0." The case of Deamonte Driver raises a question we will consider in today's hearing: do the figures used for government oversight accurately reflect the accessibility and utilization of dental care?

We will also consider the role played by the Centers for Medicaid and State Operations or CMS. The Federal government provides half or more of Medicaid funding to every state. It is a function and responsibility of CMS to ensure that that money is being spent effectively to provide dental care to Medicaid eligible children.

CMS uses the Form 416 to ensure that children receive dental care as mandated by the Social Security Act. Although the Form 416 is the only oversight mechanism used by CMS to ensure compliance with the Act, not all states submit their Form 416s annually. And as one of our witnesses today will testify, even when the Form 416s are submitted, the data may not be reliable or informative. The Form 416s do not tell us why utilization rates are low, how many children received adequate and appropriate care, how many of the children that received a screening received preventative or restorative care for that screening, how many dentists are providing the care for the children and whether or not only a handful of benevolent dentists are providing the care that should be spread across a broad network of providers. All the Form 416s tell us are how many children are enrolled in Medicaid, how many of them receive a screening, how many receive preventative care, and how many receive restorative care. Our hearing will afford us the opportunity to ask how can we confirm that dental care in Medicaid is adequate if the only information available to us is either incomplete, unreliable, or both?

We know even less about Medicaid managed care organizations. Managed care organizations do not complete Form 416s. They only report to the states. All of the data the MCOs report is created by the MCOs themselves. This is concerning since 47 states and the District of Columbia enroll some or all of their Medicaid populations in managed care. In 2004, managed care provided benefits for approximately 60% of Medicaid beneficiaries nationwide. How do numbers reported by Medicaid managed care organizations and overseen by federal agencies reflect the reality of access to and availability of dental care? What do those statistics really mean? What do they tell us about children's dental care? Do we know enough to prevent another tragedy like that of Deamonte's?

Medicaid's inability to provide adequate dental care to children has been known since ***at least*** since 2000 when the U.S. Surgeon General published his report. At the time of the report's publication, Deamonte was only five years old. A year later, on January 18, 2001, when Deamonte was six years-old, the former Director of the Center for Medicaid and State Operations, issued a *Dear State Medicaid Director Letter* (DSMD). DSMD letters are often used by CMS to provide information, guidance, and direction regarding Medicaid policy. In that letter, the Director requested information on state efforts to ensure children's access to dental services under Medicaid.

The *January 18, 2001* Letter indicated that HCFA, presently known as CMS, would undertake intensive oversight of states whose dental utilization rates, as indicated on the HCFA-416 annual reports, were below 30 percent, including site visits by Regional Office staff. States between 30 and 50 percent would be subject to somewhat less stringent review. The letter was written six years before Deamonte's tragic death—at a time when something could have been done to save him.

Significantly, Maryland was among the 15 worst performers. In 2005, the date of the most recent documentation, Maryland had just climbed out of the lowest category. That raises the question: would Deamonte's fate would have been different if CMS had subjected Maryland to a stringent review in 2001 as indicated necessary by the *January 18th Letter*? Was a critical opportunity lost to save a boy's life?

This is not a case of an unfortunate boy falling through the cracks, since the majority of Medicaid-eligible children do not receive dental care. Rather, it is a tragic consequence of a system that creates a captive population for managed care organizations and allows managed care organizations to report on themselves to government regulators. That is a system that puts profits before people.

A little boy died for lack of a dentist. A dental screening would have only cost the managed care organization in which he was enrolled about $15.

Taxpayers paid the managed care company about $4800 over the course of the last five years of Deamonte's young life to provide him with a dentist and routine screenings that he obviously never received. The managed care company's parent retained about $12.5 billion in net profits during that same period.

Mr. KUCINICH. Mr. Issa, you are recognized for a statement.

Mr. ISSA. Thank you, Mr. Chairman.

I would ask unanimous consent that all members of the committee be allowed to include their statements and extraneous material into the record.

Mr. KUCINICH. So ordered.

Mr. ISSA. Thank you, Mr. Chairman.

Now I will be brief, because there is a vote on, but I think it is important to, first of all, thank you for holding this hearing today. It is very clear that we do have a crisis within an existing system. Little Deamonte's death is not anecdotal. It may be one of the few deaths, but it is just the tip of the iceberg of people who have losses in the quality of life and probably in many cases in the length of their life.

The absence to have good dental care and preventive maintenance early on in life reduces both quality and longevity. It leads to early loss of teeth. Obviously, the abscesses, the other diseases can often be devastating, sometimes fatal. The loss of the bone due to tooth loss can lead to a number of other problems later in life.

It is clear that, although we were well meaning in the establishment of a Medicare system that relies on private health care, that over the years, as public health institutions and public health doctors have been replaced by for-profit private systems, that we have not held them accountable to the highest level.

The death of young Deamonte Driver is one of those tragedies that had no bad actors. We cannot look at malice or any wrongdoing of any of the individuals involved. What we can look to is a system that did not hold all of those involved to a standard that would have prevented this.

I, for one, recognize through my own life experience and those of my employees over the years, that, unlike health care, in general, which you may or may not need, you need preventive dental care from the time your first tooth comes in until the time you breathe your last breath, and if you do not have it, both the quality and length of life will be diminished.

So, unlike other areas of health care that you may or may not go for a period of time and feel that I don't know what is happening but I am probably OK, every absence of a tooth cleaning, every absence of a timely inspection leads to the kinds of problems that we saw here with young Deamonte Driver.

Maryland, with only 16 percent of its 5,500 dentists participating, certainly is a poster child for this problem, but, Mr. Chairman, I commend you for bringing this to national attention. This is a national tragedy. It is one that can only be solved by fundamental oversight and reforms in the system.

I commend you for bringing this beginning of the process here today. I look forward not only to this hearing but to real reform and real legislation to make sure that preventive dentistry becomes part of overall health for all of us in America, but particularly for those who cannot afford it on their own.

With that, I yield back.

Mr. KUCINICH. I want to thank the gentleman for his spirit of cooperation. I appreciate the spirit of your statement.

Without objection, the Chair and ranking minority member will have time to include extraneous materials in the record. Without objection, Members and witnesses may have 5 legislative days to submit a written statement or extraneous materials. And without objection we will be joined on the dais by Members not on our committee for the purpose of participating in this hearing, making opening statements, and asking questions of our witnesses.

I think at this point what we will do is take a brief recess of about 20 minutes. We will take a recess of 20 minutes. We are going to vote. We will be right back.

Thank you very much.

[Recess.]

Mr. KUCINICH. The committee will come to order.

This is a meeting of the Domestic Policy Subcommittee of the Oversight and Government Reform Committee. The topic for today's hearing is Evaluating Pediatric Dental Care under Medicaid.

I am Dennis Kucinich, chairman of the committee.

At this time I will ask if any other Member seeks recognition to make an opening statement.

Mr. CUMMINGS. Mr. Chairman.

Mr. KUCINICH. Mr. Cummings of Maryland.

Mr. CUMMINGS. Thank you very much, Chairman Kucinich. I take this moment to express my sincere gratitude to you for taking an interest in this important issue and agreeing to host this hearing today before the Domestic Policy Subcommittee.

Your staff had the tremendous task of organizing this hearing, and I thank them for their efforts.

I requested this hearing to investigate critical breakdowns in the Federal Medicaid program which have left so many children unable to access the dental care services that they are entitled to by law. I emphasize that—entitled to by law.

Many of you in this room will be familiar with the name of Deamonte Driver. It is for him and other children who find themselves similarly situated that I requested this hearing.

For those of you who are not familiar, allow me to explain. Deamonte Driver was a 12 year old boy from my home State of Maryland who died on February 25th when a tooth infection spread to his brain. A routine dental checkup might have saved his young life, but Deamonte's family was poor and they did not have access to a dentist.

When I read Deamonte's story in the Washington Post, I was shaken and shocked. I asked myself, how could this happen in the United States of America, a country that sends folks to the moon. How could this happen? How in the 21st century, with all the resources available to us, did we thoroughly fail this little boy?

I often say that as adults we have a responsibility to provide for and protect our children. Here, ladies and gentlemen, we simply failed to meet those responsibilities for this young man.

I think we all should be ashamed by that fact. I know I am. But shame will not correct the situations that allowed this young man to die an early death. That is why I have made it a commitment to attack the issue of insufficient access to dental care from every single angle.

In the weeks leading up to this hearing, my staff and I have met with patient advocates, dentists, dental organizations, health care providers, and Government officials to fully comprehend the scope of this problem. I have joined my colleagues in reintroducing the Children's Dental Health Improvement Act of 2007, H.R. 1781, and in working to ensure that dental coverage is included in the forthcoming State's Children's Health Insurance Program [SCHIP], reauthorization.

I have also worked with my colleagues on the House Armed Services Committee, Personnel Subcommittee, to request a Government Accountability Office study to examine the quality of dental care provided to our troops and the effects of that care on readiness.

Poor dental health is a leading cause of delayed deployment, and for many of these troops dental problems, that is right, began when they were children.

Through our work I have become acutely aware of the barriers facing Medicaid patients who seek dental care. More and more, dentists are not accepting Medicaid insurance because it pays only $0.20 to $0.35 on the dollar. Further, Medicaid patients are more likely to cancel appointments, and the paperwork burden is large.

Finally, I know also that there is a shortage of dentists capable of doing this work. Many dentists are uncomfortable treating the sort of complicated cases presented by Deamonte and others who have not had regular access to care.

The University of Maryland Dental School, the only dental school in the State of Maryland, graduates just three pediatric dentists per year. But our purpose today is not to address the issue of access to dental care. That is a role better played by the authorizing committees. Today we will investigate the systematic failures of the Centers for Medicaid and Medicare Services and its State partners to comply with the section 1905(R)(3) of the Social Security Act, which ensures that every Medicaid eligible child will have access to medically necessary dental care under the early periodic screening, diagnostic, and treatment, or SDSDT, provision.

We know that this service was not extended to Deamonte Driver. Evidence suggests that he is certainly not alone. I think it is worthwhile to take another look at the chart the chairman just put up. As this chart indicates, of the 24 dental offices listed as Medicaid providers in the State of Maryland that the committee staff called, 23 were disconnected, incorrect, or belonged to a dentist who does not take Medicaid patients. The 24th was an oral surgeon, not a dentist.

At my request the majority staff of the committee has prepared an analysis of the alterations of the guide created by a leading pediatric dentistry organization to Children's Dental Care and Medicaid.

I ask unanimous consent, Mr. Chairman, that this analysis be included in the record of today's proceedings.

We must do everything in our power to identify what went wrong and to fix the broken system not yesterday but now. I simply cannot and we cannot allow another child to suffer Deamonte's fate.

I look forward to the testimonies of today's witnesses and again, Mr. Chairman, I thank you so very much for acting on this so expeditiously and so thoroughly.

With that, I yield back.

Mr. KUCINICH. I thank the gentleman. Without objection, the information that you requested be included in the record will be included. So ordered.

The Chair welcomes and wishes to recognize for purposes of an introduction Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. Thank you for holding the hearing.

Thank you to you, Congressman Cummings, for requesting a hearing, and thank you for your continued incredible leadership on behalf of the State of Maryland.

I wanted to join you very briefly this morning to join you in welcoming one of the witnesses today, Laurie Norris. I had the opportunity to work with Ms. Norris for 7 years when I was on the board at the Public Justice Center in Baltimore. I know of her good work. I know of her incredible skills as an advocate and a lawyer, particularly on behalf of under-served families and communities and children. I know that her testimony today will be compelling, and I expect wrenching at times, but it is incredibly important.

I thank you again for the opportunity to join in welcoming her today.

Thank you.

Mr. KUCINICH. I thank the gentleman.

The subcommittee will now receive testimony from the witnesses before us today.

I want to start by introducing our first panel.

Ms. Laurie Norris, I want to thank you very much for your presence here.

Dr. Frederick Clark has practiced dentistry in Prince George's County for the past 17 years. Dr. Clark has served on the State of Maryland Oral Health Advisory Committee. He has also served as a member of the HeadStart Advisory Committee.

Welcome.

Dr. Norman Tinanoff is a practicing pediatric dentist in Baltimore and is a professor and chairman of the Department of Health Promotion and Policy at the University of Maryland Dental School. Dr. Tinanoff has authored over 50 articles concerning preventing dental care carries and oral health access in under-served child populations. Before joining the University of Maryland, Dr. Tinanoff was the director of the Pediatric Dentistry Graduate Program at the University of Connecticut's Health Center for 16 years. Dr. Tinanoff has also served at the Army Institute of Dental Research at the Walter Reed Army Medical Center.

Welcome, Doctor.

It is the policy of the Committee on Oversight and Government Reform to swear in all witnesses before they testify, and I would ask the witnesses to please rise and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Let the record reflect that the witnesses answered in the affirmative.

I ask that each witness now give a brief summary of their testimony, and to keep the summary under 5 minutes in duration. I want you to bear in mind that your complete statement will be included in the hearing record.

Ms. Norris, you will be our first witness. At this point we welcome your testimony. Thank you.

STATEMENTS OF LAURIE NORRIS, STAFF ATTORNEY, PUBLIC JUSTICE CENTER; FREDERICK CLARK, D.D.S, DENTIST, PRINCE GEORGE'S COUNTY, NATIONAL DENTAL ASSOCIATION, MEMBER; AND NORMAN TINANOFF, D.D.S, CHAIR, DEPARTMENT OF PEDIATRIC DENTISTRY DENTAL SCHOOL, UNIVERSITY OF MARYLAND

STATEMENT OF LAURIE NORRIS

Ms. NORRIS. Thank you, Chairman Kucinich and members of the committee. I have the pleasure to be here today, but the sad duty of telling you the story of Deamonte Driver and his family.

I assisted Deamonte's mother in trying to get dental care for her children. Let me just briefly summarize what happened when I tried to do that.

Deamonte was the third of five children in his family, all boys. They were born and raised in rural Prince George's County, MD. They were at high risk for dental disease because they were a low-income family, and Deamonte especially because he was a later-born child. He was the third child in the family.

All children in the family had a medical home. They all had a pediatrician that they could go to for regular childhood illnesses and immunizations, but none of the children in the Driver family had a dental home. They did not have a primary care dentist to look after their preventive dental care needs, their regular check-ups, or dental education.

As we have heard, Deamonte was 12 years old. During the course of this story, Deamonte had a younger brother, DeShawn, who was 10 in the summer of 2006, and I really want to start with him.

All the boys were enrolled in United Health Care Medicaid managed care. In the summer of 2006, DeShawn started to experience dental pain and swelling, and his mother worked to find a dentist to treat him. And she was successful. She did find a contracted dentist through United and took DeShawn to the dentist, but the dentist refused to treat DeShawn because he wiggled too much in the chair. She sent him away and she didn't help the mother find another dentist to treat DeShawn. The mother tried, but was unsuccessful in finding another dentist, and so she called me in September 2006.

I agreed to take the case and to help her out, and I called United Health Care directly to try to find a contracted dentist, and they referred me to Dental Benefit Providers, which is their dental subcontracted administrator. The DBP folks sent me a list of contracted dentists in DeShawn's geographic area, but they warned me to check first to see if the dentist still accepted United Health Care, because they said a lot of the dentists had recently dropped the contract.

I had my administrative assistant start at the top of the list. She called the first 26 names on the list and none of them agreed to take DeShawn as a patient because they said they didn't accept that insurance.

So at that point I called the State Agency Department of Health and Mental Hygiene. They have a help line. I called there and eventually, through their case management unit and the Prince George's County local Health Department, and assistance from United Health Care, we did find a dentist for DeShawn in October. It took one mother, one lawyer, one help line supervisor, and three case management professionals to make a dental appointment for one Medicaid child.

But finding the dentist was just the beginning. DeShawn saw this dentist on October 5, 2006 and learned that he needed to have six teeth pulled. DHMH assisted with finding an oral surgeon, but the first available appointment was November 16th, 6 weeks later. DeShawn went to that appointment. It was a consultation. No treatment was given.

A December appointment was set. The dentist canceled that appointment. A January appointment was set. The dentist canceled that appointment, too, because he said by then he had dropped the plan.

So DeShawn still has six rotten teeth in his mouth, no dental treatment. It is now 6 months later.

DHMH located a third oral surgeon and a first appointment was set for February 7, 2007, and DeShawn did have his first tooth pulled. That dentist recommended that DeShawn have one tooth pulled each month for the next 5 months.

So let's go back to Deamonte for a minute now. Deamonte had not complained of any dental problems. Nobody in his family knew that he had dental issues. He did begin experiencing severe headaches and he was diagnosed with a sinus infection in early January 2007. On January 12th, he was rushed to the hospital, had emergency brain surgery, and 6 weeks later, as we have heard, he passed away.

Now, DeShawn eventually did get all six of his teeth pulled, but that was only because he transferred his care to the University of Maryland Dental Clinic, Dr. Tinanoff's clinic, and was expeditiously taken care of, and so we still have DeShawn with us today.

I hope it is obvious that if we substitute the name Deamonte for DeShawn in DeShawn's story, the result is the same. Deamonte would still have had his brain infection. It took 7 months for Ms. Driver to get treatment for DeShawn, even though she was actively seeking it and doing everything she could think of to access that care.

As we have heard, Deamonte and DeShawn are not exceptions.

I will just close by saying that at the Federal level it seems to me that there has been a toleration for gross under-performance by the States in providing oral health to our children, and that just needs to stop.

Thank you, Chairman.

[The prepared statement of Ms. Norris follows:]

TESTIMONY OF
THE PUBLIC JUSTICE CENTER
TO THE
SUBCOMMITTEE ON DOMESTIC POLICY
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

ON

THE STORY OF DEAMONTE DRIVER
AND ENSURING ORAL HEALTH FOR CHILDREN ENROLLED IN MEDICAID

SUBMITTED BY

LAURIE J. NORRIS, ESQ.

MAY 2, 2007

Chairman Kucinich, Congressman Issa and members of the Committee, thank you for inviting me here today to testify concerning the state of access to oral health care for low-income children in our country.

On February 25, 2007, Maryland's Deamonte Driver, age 12, died as a result of an untreated infected tooth which led to a massive brain infection.

It is truly a shame on all of us that Deamonte had to serve as the proverbial canary in the coal mine. But let us not fail to heed the warning hid death provides. Let us not, by our indifference or incompetence, have to bear on our consciences the burden of more dead children.

We have a health care crisis on our hands – a dental care crisis – and we have had for quite some time. Somehow, it has been all right for us to ignore it. I hope it is not all right for us to ignore it any longer.

It is time for us to retire the myth that dental care for young children is desirable but not essential; that cavities in baby teeth can be tolerated because the teeth will fall out anyway. Dental disease in young children is a very serious matter, with very serious consequences indeed, including death.

You will hear a great deal of testimony today about the medical aspects of dental disease, the fact that it is epidemic among poor children, and the efforts of dentists and of federal and state agencies to address the epidemic. And I will talk a little about some of those topics as well.

But first I want to tell you Deamonte's story.

Deamonte's Story

Deamonte was born and raised in Prince George's County, Maryland. He was the third of five children, all boys. Deamonte's parents and grandparents always scrabbled to make ends meet, making do in whatever way they could in rural southern Maryland. The adults were used to being uninsured; but the children usually had insurance -- through Medicaid or the Maryland Children's Health Program.

Dental disease in the Driver family followed a typical pattern. Oral health researchers tell us that dental caries is a transmissible and infectious bacterial disease, that it typically passes from mother (or caregiver) to infant, and that each subsequent child born to a mother tends to have a higher risk of infection and disease than the previous child.[1]

Deamonte's mother, Alyce Driver, being uninsured and poor, did not have regular dental care. Predictably, her children, as are most children, became colonized with the bacteria that causes dental caries. And the disease seemed to be worse in each subsequent child. The first two boys experienced relatively little dental disease. Then came Deamonte,

who obviously had some oral disease. And his two younger brothers also have struggled with significant oral infection.

The Driver boys all had a primary care doctor - a medical home - a pediatrician who treated their childhood illnesses, gave them their immunizations, made sure they were healthy to play sports. He was accessible and responsive to their health care needs.

But the Driver boys never had a regular primary care dentist - a dental home - an identified provider who could assess their risk for developing dental disease by age 1, check their mouths and new teeth every six months during toddlerhood, provide education to their parents about preventing dental disease, instruct the boys in how to properly brush and floss, recommend fluoride treatments and dental sealants as they grew older, clean their teeth every six months, and watch for developing cavities that could be nipped in the bud, preventing severe disease, pain, tooth loss, and, in Deamonte's case, death.

Researchers have determined that poor children are at much higher risk of contracting dental disease than are non-poor children. In addition, low-income parents are much less likely to be aware of the risks of oral health disease, and of the need for and availability of preventive dental care. The Driver family was no exception. The family's socio-economic status put the children at high risk to begin with. In addition, Ms. Driver's own lack of access to dental care as a child and as an adult, coupled with the barriers to getting dental care for her children, has meant that she has not had the opportunity to fully understand the importance of good oral health in young children and how to maintain it.

I first met the Driver family in July 2006 through my work on homeless children's education rights in Prince George's County, Maryland. The Public Justice Center was conducting interviews of selected homeless families to understand their experiences with the public school system, and Ms. Driver was one of the parents we interviewed. Then, in August, 2006, Ms. Driver contacted me for help in getting her children enrolled in school.

Now, I need to divert from Deamonte's story for a bit, and tell you about his brother, DaShawn.

In September, 2006, Ms. Driver called me to ask if I could help her find a dentist for 10-year-old DaShawn. He had severe abscesses in his mouth that were causing swelling and pain. Ms. Driver knew he needed to have some teeth pulled, and she had taken him to an oral surgeon over the summer, but that dentist had refused to treat DaShawn because he couldn't hold still enough in the dentist's chair. That dentist did not give Ms. Driver a referral to another dentist, so she wasn't sure where to turn. She called a toll-free number to try to locate another dentist contracted with DaShawn's Medicaid managed care plan, but was unsuccessful. She had reached the limit of her understanding and ability to navigate Maryland's complex Medicaid system.

I agreed to help Ms. Driver find a dentist for DaShawn. There my odyssey began. After confirming that DaShawn was enrolled in Maryland's Medicaid HealthChoice program, and that his managed care plan was United Healthcare, I called the United Healthcare customer service number. From there I was transferred to the plan's dental benefits administrator, a separate company called Dental Benefit Providers, or DBP. The very helpful customer service representative explained that DaShawn would first have to see a general dentist to get a referral to an oral surgeon in order to get the treatment he needed. She also explained that the Medicaid part of the United Healthcare company was called Americhoice, and that this was the company the dentists would be contracted with, not United Healthcare. She searched her database and forwarded to me a list of several dozen general dentists located near where DaShawn was staying at that time - with his grandparents. She cautioned me that while these dentists were supposed to be in the DBP network, and thus contracted with Americhoice (United Healthcare Medicaid), many of them had recently been dropping their contracts. She advised me to ask first whether the dentist contracted with "Americhoice through the State." Only a dentist that confirmed this would be a participating dentist in DaShawn's Medicaid plan.

My administrative assistant started calling dentists on the list, asking if they accepted "Americhoice though the State." The first 26 dentists on the list said, "No." At this point I decided that another approach was needed. I called the Department of Health and Mental Hygiene's (DHMH) Medicaid enrollee helpline. I explained the problem I was having and asked for help. The first person I spoke to argued with me for 5 minutes about what the problem was, insisting that she couldn't find DaShawn in the computer and that he must be enrolled in a Medicaid managed care plan called Amerigroup, not United Healthcare. I asked to speak to a supervisor. The supervisor understood the problem right away, was able to find DaShawn in the computer, and agreed that I needed help. She transferred me to the supervising nurse in the case management unit at DHMH.

Over the next 5 days, the DHMH case management nurse, a case manager at the Prince George's County Health Department's ombudsman unit, and an employee at United Healthcare/Americhoice worked together to find a contracted dentist for DaShawn. Finally, he saw a general dentist on October 5, 2006.

It took the combined efforts of one mother, one lawyer, one helpline supervisor, and three health care case management professionals to make a dental appointment for a single Medicaid-insured child!

And yet, DaShawn's path to adequate dental care was not yet over. DaShawn's new dentist determined that DaShawn needed to have six teeth pulled by an oral surgeon. Again I contacted the DHMH case management nurse, who with the cooperation of the other case management professionals, located a contracted oral surgeon. Ms. Driver secured the earliest available appointment for DaShawn -- November 16, 2007.

The oral surgeon agreed that six teeth needed to be extracted, and scheduled the first extraction for late December 2006. That appointment was subsequently cancelled by the oral surgeon (reportedly because of an emergency in his office), and rescheduled for early

January. But by the time the January appointment rolled around, that oral surgeon had cancelled his contract with United Healthcare/Americhoice. So DaShawn had to find a yet another oral surgeon -- his third. He finally had his first tooth pulled in February 2007. The third oral surgeon suggested pulling one tooth each month for six months.

In the meantime, two other relevant events occurred. First, 12-year-old Deamonte, who had not complained of any dental problems, began experiencing severe headaches. Over the period of a week or so in mid-January 2007, he was first diagnosed with a sinus infection, and then with a brain infection. He had two brain surgeries, had one tooth extracted, and spent six weeks in the hospital, where he seemed to be recovering well, but where he died unexpectedly on February 25, 2007.

Though Deamonte's story had the worst possible ending, DaShawn's story ended more happily. Because of Deamonte's experience, Ms. Driver had extreme concern for DaShawn's ongoing oral health situation. DaShawn's second of six rotten teeth was pulled by the third oral surgeon in March 2007, but no dentist had put him on antibiotics, and Ms. Driver did not want to wait four more months to get the remaining four teeth pulled. Because of Deamonte's death, she learned of the pediatric dental clinic at the University of Maryland dental school, and decided to transfer the rest of DaShawn's care to them. There, his four remaining infected teeth were pulled promptly.

Deamonte Was Not an Exception

Now let me move from the particular to the general. The sad thing is, we can be absolutely certain that the experience of the Driver family is not in any way unique to them. We know this because:

- low-income children have about 80% of the dental disease in this country;
- more than 50% of low-income preschool aged children in Maryland have dental decay;
- and 98% of that dental decay is untreated, each child having an average of 3 untreated cavities;
- only 31%-45% of Maryland's continuously enrolled Medicaid children ages 4-20 (representing perhaps half of Maryland's Medicaid children in that age group) saw a dentist in 2005;[2]
- and only 13%-16% of those children got any restorative treatment (e.g. filling for a cavity).[3]

From these statistics, it is clear that the typical low-income child in Maryland has dental disease and untreated dental decay. And only a very small percentage of these children are receiving any dental treatment. So it is more than safe to assume that most children in Maryland's Medicaid program are having a tough time getting access to all the dental care they need. In addition, other parents of children on Medicaid have shared with me their experiences in trying to find a dentist for their children, or in trying to find the right kind of dentist who can treat the specific dental problems their children are experiencing. They have told me:

- Of inaccurate provider lists
- Of having to call many, many dentists before finding one that is contracted, or that will accept a new patient
- Of having to wait months for an appointment
- Of having to drive long distances, e.g. more than an hour, to get to a dentist who will accept their Medicaid card
- Of being turned away at the office on the day of the appointment for unexplained reasons

Maryland Has Had A Troubled History in Oral Health

We have a particularly troubled history in Maryland concerning access to dental care in Medicaid. In 1997, our State ranked dead last in access to oral health care services for poor children. We have progressed somewhat since then, but some of that progress is due to some data "slight of hand." For example, Maryland uses HEDIS data in its annual report to the State legislature about dental utilization.[4]

The HEDIS measure was specifically designed and intended to be used to permit comparison between insurance plans or HMOs. Thus, understandably, the measure suggests that only persons enrolled continuously in a particular plan (with not more than a single break in enrollment of 45 days or less) be counted in the analysis for that plan. Even though in its reporting Maryland purports to measure the overall performance of the entire HealthChoice program, not the individual performance of each of the seven participating managed care organizations, Maryland insists on excluding from the analysis all children who failed to maintain continuous enrollment of at least 320 days *in a single managed care organization.* This results in the elimination from the analysis of many children, perhaps half of all enrolled children, especially children from lower-income families, because these children tend to experience a greater rate of disruption in their Medicaid coverage. Tellingly, while Deamonte and DaShawn were both insured by Medicaid for many years, they both probably will be excluded from the analysis for 2006 because of a 63-day break in enrollment with the United Healthcare MCO.

Current Performance Measures Are Inadequate

Historically, dental access in Medicaid has been measured by looking at the percentage of children who have had at least one dental encounter during a given year. It has become abundantly clear that these measures are wholly inadequate to describe the state of oral health of our country's low-income children. Nor are these measures serving to lead us toward the reforms needed to address the severe deficit in care that exists.

As long ago as 1998, an expert panel commissioned by CMS determined that the current measures should be replaced by new measures: *Use of Dental Services by Children* profiling the range of different types of services provided, as well as measures to begin to address the domains of effectiveness of care, satisfaction with the experience of care, involvement in decision making and the cost and value of care.[5]

It is long overdue that CMS develop these new measures, and require States to use them.

Many Resources Are Available to Guide Reform

The problem of access to oral health care for poor children has been a long-standing one and has been studied extensively. As a result of all this study, we know what causes children to become infected with oral bacteria leading to dental caries.[6] We know that the disease is a systemic, endemic, chronic and epidemic problem among poor children.[7] We know the nature of the numerous obstacles to ensuring that poor children receive adequate dental care.[8,9] We have a pretty good idea of what we need to do, from a medical and policy standpoint, to eliminate these obstacles.[10,11,12,13] And there are models for effective dental care delivery systems for low-income children.[14,15,16]

What we seem to be lacking is the political will to challenge the corporate interests that benefit from the current arrangement, to spend the money it will take to provide truly adequate levels of care to this neglected population and to prevent a recurrent disaster in the next cohort of children, and to provide adequate federal oversight of program performance.

A culture has grown within certain levels of CMS and within some of our State's agencies that clearly condones gross underperformance in Medicaid, particularly in terms of low profile areas such as access to oral health care. Any elementary school child knows that if they pay for something but don't get it, they are not going to pay the same person again and again. CMS needs to understand and act on this same principle. States know that CMS will keep paying and not enforce their waiver conditions or federal law regarding adequate access to care. The CMS employees responsible for overseeing State programs know there is no likelihood of enforcement by their agency so they lose heart and perpetuate the problem. The culture of accepting underperformance becomes widespread and entrenched. It becomes all too easy and common for access to dental care to reach unacceptable levels. The system fails. The taxpayer and children are abused.

This problem can be fixed, but Congress must insist on accountability and performance as well as provide CMS with the necessary tools to get the job done.

What CMS Can Do

- Require every State to comply with OBRA89 by developing and publishing a distinct *dental* EPSDT periodicity schedule, with dental care beginning no later than age 1 as recommended by the American Academy of Pediatric Dentistry and the Medicaid/SCHIP Dental Association.
- Require every State to actively monitor, and report to CMS concerning, participating dentists' compliance with the State's dental EPSDT periodicity schedule.

- Begin immediately to require States to report to CMS on dental access for, and the oral health status of, the age cohort **1** to 20.
- Require every State to provide a "dental home" for each child enrolled in a State plan.
- Effectively enforce current oral access standards as described in the January 18, 2001 Dear State Medicaid Director Letter, SMDL #01-010.
- Effectively enforce existing Terms and Conditions in states with Medicaid managed care under an 1115(b) waiver.
- Implement performance measures, and require States to report to CMS using them, to address the domain of effectiveness of care, looking at dental outcomes for these children, consistent with the recommendations of the CMS/NCQA Pediatric Oral Health Performance Measures Project.
- Develop and implement a high visibility long-term nationwide public education campaign about the importance of oral health in children and how to achieve it, similar to the "back to sleep" campaign which has so successfully reduced the occurrence of sudden infant death syndrome (SIDS) in the United States.
- Enforce meaningful sanctions (withholding of federal financial participation) against States that fail to meet specified performance measures for achieving oral health for children enrolled in a State plan (see What Congress Can Do, below).
- Develop a portfolio of model State dental delivery systems based on State programs that meet specified performance measures and achieve oral health for enrolled children, and coach failing States to adopt or adapt these models.

What Congress Can Do

- Insist that CMS do everything on the above list.
- In the context of H.R. 1781:
    - Make it a prerequisite that a State applying for a grant under Section 101
        - Develop a *strategic* plan for *ensuring the achievement of oral health* for children enrolled in a State plan under title XIX or a State child health plan under title XXI (including a description of the size of the unmet need); and that data collection and reporting include outcome performance measures intended to measure achievement of, and maintenance of, oral health.
        - That "adequate payment rates" be defined as those rates sufficient to enlist enough dentists to ensure the achievement of oral health in children enrolled in the State plan, and require the State to ensure that it will raise rates to these levels.
    - Revise Section 102(b) to require States to report to CMS using outcome-based performance measures, as recommended by the CMS/NCQA Pediatric Oral Health Performance Measures Project, instead of the repeatedly discredited CMS 416 EPSDT participation measures.
- Enact meaningful sanctions (withholding of federal financial participation) against States that fail to meet specified performance measures for achieving oral health for children enrolled in a State plan.

- Demand that CMS provide adequate, even aggressive, oversight of State Medicaid programs and enforcement of waiver conditions and federal laws to ensure that taxpayer dollars allocated to oral health services are accountably and effectively spent on oral health services, and that State's Medicaid oral health delivery systems are rationally designed and effectively managed.
- Hold CMS accountable for enforcing the January 18, 2001 Dear State Medicaid Director Letter, SMDL #01-010.

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[1] *Oral Health Risk Assessment Timing and Establishment of a Dental Home*, PEDIATRICS, Vol. 111 No. 5, May 2003.

[2] A range of percentages is given because of inconsistent reporting by DHMH between the CMS 416 EPSDT dental utilization data and HEDIS dental utilization data.

[3] See endnote 2.

[4] See *Report to the General Assembly: Dental Care Access under HealthChoice*, October 2006.

[5] See *Guide to Children's Dental Care in Medicaid*, CMS, October 2004, p. 18.

[6] See *Oral Health Risk Assessment Timing and Establishment of a Dental Home*, American Academy of Pediatrics, PEDIATRICS, Vol. 111 No. 5, May 2003, pp. 1113-1116.

[7] See *Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations*, U.S. General Accounting Office, GAO/HEHS-00-71, April 2000.

[8] See, for example, Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations, U.S. General Accounting Office, GAO/HEHS-00-149, September 2000.

[9] *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*, Laura Summer and Cindy Mann, Georgetown University Health Policy Institute, June 2006.

[10] *Guide to Children's Dental Care in Medicaid, CMS, October 2004.* See especially pages 3-6, Contemporary Dental Care for Children, and pages 6-19, Policy and Program Considerations.

[11] *American Academy of Pediatric Dentistry, 2006-2007 Definitions, Oral Health Policies and Clinical Guidelines*, available at http://www.aapd.org/media/policies.asp .

[12] *Opportunities to Use Medicaid in Support of Oral Health Services,* U.S. Dept. of Health & Human Services, Health Resources & Services Administration, December 2000.

[13] See the many excellent policy materials available on the website of the American Academy of Pediatric Dentistry, http://www.aapd.org/ .

[14] *Pediatric Dental Care in CHIP and Medicaid: Paying for What Kids Need/Getting Value for State Payments*, Milbank Memorial Fund, Reforming States Group, 1999.

[15] *Michigan Medicaid's Healthy Kids Dental Program: an assessment of the first 12 months,* Stephen A. Eklund, James L. Pittman, Sarah J. Clark, JOURNAL OF THE AMERICAN DENTAL ASSOCIATION, Vol. 134, November 2003, pp. 1509-1515.

[16] *Medicaid EPSDT - State Innovation Leads to Improved Oral Health Participation Rates*, National Health Law Program, February 2006.

Mr. KUCINICH. Dr. Clark, thank you. You may proceed.

STATEMENT OF FREDERICK CLARK

Dr. CLARK. Thank you very much, Chairman Kucinich, members of the committee. Thank you for inviting me to testify today.

Mr. KUCINICH. Dr. Clark, before you begin, I want to note that we have been joined by the distinguished Congresswoman from California, Congresswoman Watson.

Dr. CLARK. My name is Dr. Frederick Clark. I have been a practitioner in Temple Hills, MD, Prince George's County, for some 17 years. I am a dental health care advocate.

I am here today because a child in my county and in my city in Temple Hills, MD, lost his life because he couldn't receive dental care in a timely manner. I am here to provide my personal perspective on problems related to access to care for children in the Medicaid program, and those who are uninsured and barriers that may exist in Prince George's County.

I feel that one of the primary barriers to access is lack of adequate participation by private dental offices in the Medicaid program. Prince George's County has approximately 43,000 to 50,000 child Medicaid participants. Some 200 dental offices are listed as providers, according to the Prince George's County Health Department, but when those offices were contacted to check on their participation, only 25 percent of those offices would see a child Medicaid patient.

With this disproportionate ratio of patients to providers, it is virtually impossible for a parent to find a dentist to treat a child's dental concerns. Why does this disparity exist? There are many reasons, but some cited were, of course, low reimbursement rates for dental services, inability to receive timely payments for services rendered, inadequate network of specialists in which to refer difficult cases, poor communication between dental providers and the managed care organizations, interference with the doctor/patient relationship, difficulty in the credentialing process, and high broken appointment rates amongst Medicaid patients.

For years dentists have had difficulty participating in Medicaid programs, even before the plans were taken over by managed care organizations. Some of the same complaints existed for years, resulting in refusal by many offices to participate in Medicaid. HMOs and MCOs have created a new landscape in which the medical field has had to adapt, but the changes have not been favorable to doctors.

The way managed care plans are structured inherently create an antagonistic relationship within the medical and dental communities due to fee setting, low co-payment by patients, non-negotiation with the providers of care to provide payments, and low capitation rates.

The combination of managed care plans and Medicaid makes an unpalatable mix that most doctors refuse to have any part of.

At the treatment level, there is a silent scream which we in the treatment community hear on a daily basis. At Ground Zero there is a constant inundation of phone calls of patients attempting to acquire appointments. Parents report of calls to numerous offices and inability to receive appointments. There are reports of children in

pain, children with abscesses. When children can be seen, there may be three, four, five children in a single family, all of whom have a number of cavities and dental disease.

Sometimes they can be treated if a child is manageable, but if they are not the search begins for a pediatric dentist, which is almost impossible to find. A search through our local Yellow Pages revealed that there were only four listings for pediatric dentists in a county which has 800,000 residents and 50,000 child Medicaid recipients.

I have served this Medicaid population, in spite of problems of low compensation, and in some instances refusal to be paid. I grew up in south central Los Angeles as a poor child, and I feel a commitment to treat these children who know that if I were not there, there would be no one to serve them, there may be no one to serve them.

The patients who pay for services allow me to treat some of the patients who have little or nothing. Pro bono care is a part of the norm in our community. This also occurs in treatment of adults who are indigent.

Dental Medicaid dollars ultimately are allocated to ensure that poor children are able to receive desperately needed health services. The managed care role in this process is to create the network of providers and set up a compensation structure that ensures that the process works.

My primary concern is that Medicaid dollars should go the Medicaid treatment and as little as possible to administrative costs. This program was not set up for someone to profit off the backs of children. I do not begrudge a for-profit business making Native American profit, but this program was designed to help children and should be run as a nonprofit organization with open books, so that the bottom line of the business is not the primary concern.

I am not in a position to say if the managed care organizations have anything to hide, but obviously the fees are still too low to encourage private dental office participation in Medicaid.

Thank you very much.

[The prepared statement of Dr. Clark follows:]

Dr. Frederick Clark
Dental Practitioner
Temple Hills, Maryland

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Wednesday, May 2, 2007 — 2:00 P.M.
2154 Rayburn HOB

My name is Dr. Fredrick Clark. I have been a dental practitioner in Temple Hills, MD in Prince George's County for seventeen years. I am also a Dental Child Care Advocate. I have in the past served on the State of Maryland Oral Health Advisory Committee and also a past member of the Headstart Advisory Board. I have treated children in Medicaid plans throughout my entire dental career. I am here today because a child from my county lost his life because he could not receive dental treatment in a timely manner. I am here to provide my personal perspective on problems related to access to care for children in the Medicaid program and those who are uninsured and barriers that may exists in Prince George's County. I feel that one of the primary barriers to access is lack of adequate participation by private dental offices in the Medicaid program. Prince George's County has approximately 45-50,000 child Medicaid participants. Some 200 dental offices are listed as providers according to the Prince George's County Health Department. But when these offices were contacted to check on their participation, only 25% of those offices would see child Medicaid patients. With this disproportionate ratio of patients to providers, it is virtually impossible for a parent to find a dentist to treat their child's

dental concerns. Why does this disparity exist? There are many reasons, some of the reasons cited were:

- Low reimbursement rates for dental services
- Inability to receive timely payment for services
- Inadequate network of specialists in which to refer difficult cases
- Poor communication between Dental Providers and MCO's
- Interference with the Doctor-Patient relationship
- Difficulty in the credentialing process
- High broken appointment rate among Medicaid patients

For years Dentists have had difficulty in participating in the Medicaid programs even before the plans were taken over by MCO's. Some of the same complaints existed for years resulting in refusal by many offices to participate in Medicaid. HMO's and MCO's have created a new landscape in which the medical field has had to adapt but the changes have not been favorable to the Doctors. The way Managed Care Plans are structured inherently create an antagonistic relationship within the medical and dental communities due to fee setting, low co-payments by patients, non-negotiation with the providers of care to improve payments and low capitation rates. The combination of Managed Care Plans and Medicaid makes for an unpalatable mixture that most Doctors have refused to have any part of.

At the treatment level, ground zero, there is a constant inundation of calls of patients attempting to acquire appointments, parents report of calls to numerous offices and the inability to receive appointments. There are reports of children in pain, children with abscesses, when children can be seen there may be 3, 4 or 5 children in a single family, all of whom may have a number of cavities. Sometimes they can be treated if the child is manageable, if not, the search begins for a pediatric dentist which is almost impossible find. A search through the local yellow pages revealed that there were only four listings for pediatric dentists in a county which has 800,000 residents and 50,000 child Medicaid recipients. I have served the Medicaid population in spite of problems of low compensation and in some instances refusal to be paid. I grew up in South Central Los Angeles as a poor child and I feel a commitment to treat these children, who I know that if I were not there, there may be no one to serve them. The patients who pay for services allow me to treat some of the patients who have little or nothing. Pro bono care is a part of the norm in our community. This also occurs in treatment of adults who are indigent.

Enrollment in the MCO entails filling out a long document of almost 20 pages and credentials must be sent, the waiting period for the in-house credentialing to be completed may take months. Also an office inspection must take place to insure that the Doctors office meets numerous specified requirements (cleanliness, sterilization procedures, OSHA Guidelines, Records keeping, etc).

Dental Medicaid dollars ultimately are allocated to insure that poor children are able to receive desperately needed health services. The MCO's role in this process is to create

the network of providers and set up a compensation structure that insures that the process works. My primary concern is that Medicaid dollars should go to Medicaid treatment and as little as is necessary to administrative cost. This program was not set up for someone to profit off the backs of children. I do not begrudge a for-profit business making a profit but this program was designed to help children and should be run as a non-profit organization with open books so that the bottom line of the business is not the primary concern. I am in no position to say if the MCO's have anything to hide but obviously the fees are still too low to encourage private dental office participation in Medicaid.

Many factors could be put in place to make the system more responsive, such as:

- Involving dental organizations to participate in the fee setting process, this would insure the compensation structure necessary to encourage participation by the private dental sector.
- Create an efficient safety net program that insures that a parent knows where to take a child in case of pain or distress.
- Create an effective referral network of specialists to treat difficult or emergency cases which may be outside the scope of care of the general dentist.
- Encourage government to increase funding to the National Health Service Corp to train and place more pediatric dentists in areas of need or shortage.
- Create effective patient education information on dentistry and engaged in media campaigns to educate the public about dental diseases and preventive care, by use of Public Service Announcements via television and radio ads.

- Look to alternative programs to administer Medicaid services, encourage best practice models, and fund county health clinics to hire dentists and dental hygienists.
- Each State needs a Chief Dental Officer to coordinate the Public Health Dental needs of the State.

Mr. KUCINICH. We thank the gentleman.

Dr. Tinanoff.

STATEMENT OF NORMAN TINANOFF

Dr. TINANOFF. Chairman Kucinich and members of the Subcommittee on Domestic Policy, thank you for inviting me here today to discuss the issues of oral health care for poor children, especially the situation in Maryland.

I would like to give you my perspective on how, in one of the richest States in the country, Medicaid can fail our most vulnerable children, as evidenced by the most recent tragic death of a child due to a dental infection.

In 1997, access to oral health care for Maryland's poor children was the worst in the country; however, there has been incremental progress made, primarily through the enactment of Maryland State legislation championed by key legislators and promoted by oral health advocates. Nevertheless, much more progress is needed, as many Maryland children still suffer from pain and infection from oral conditions and parents continue to struggle to find dental providers to get the needed reparative services for their children.

I am going to give you an analysis of some of the oral health care issues in Maryland and compare these to the several Maryland Department of Health and Mental Hygiene's—that is DHMH—reports.

The DHMH October 2006, report lists 918 unduplicated Medicaid providers. A more realistic calculation of the actual providers may be generated from direct calling of those dentists who are on the provider list who ask the question, will you take a new Medicaid patient? Using this method, the following information was obtained from 748 of the listed 918 providers. This table shows that there is perhaps only one-fifth the actual number of listed Medicaid providers who will see a new patient.

DHMH's 2006 report also lists a number of children receiving dental services counting only those children ages 4 to 20 who have been enrolled for at least 320 days. However, the April 2005, report of the National Oral Health Policy Center mandates that States use form 416, which requires counting total eligible children. This table compares, for 2005, the number of children enrolled in Medicaid and the percent receiving any dental service, as reported by Maryland's DHMH and as reported by CMS's form 416.

Additionally, the last columns show the ratio of dental providers to enrollees for 2006, as reported by DHMH. This should be dentists, not children. With this, it shows that with DHMH they report one dentist for 439 children. Yet, if one uses the total eligible number of children that is in form 416 per the number of providers, those willing to accept a new patient, the ratio would be about one dentist for every 2,500 children, exceeding the ratio of 1 to 2,000 as required by Maryland law.

In 2001 DHMH conducted town meetings to assess issues regarding the Medicaid system. Although these meetings concerned total health care in the system, reports from those who attended these meetings indicated that most of the discussions focused on lack of access to oral health care. However, of the four quality reports of

managed care published by DHMH in 2005 and 2006, only one of 118 pages of these reports addresses oral health care.

It is difficult to appreciate why these reports essentially do not include oral health care issues, since access to oral health care has been a continued concern in Maryland for so many years.

Although the reimbursement rates for 12 selected restorative procedures were increased in 2003, most of the rates for procedures still are far below what the dentist will accept. The American Dental Association survey of March 2004, ranks Maryland as 39th out of 50 States regarding reimbursement rates for diagnostic and preventive procedures. Incredibly, this report lists Maryland as the worst State in the country for reimbursement rates for restorative procedures.

An illustration of this problem is the current reimbursement rate for dental sealings. Maryland Medicaid pays $9 per sealing, whereas the 50th percentile for dentist fees in Maryland for sealing is $40. It is unreasonable to expect a high number of dentists to participate in Medicaid when their rates do not cover their overhead costs and do not equal an acceptable discount rate for dentist participation.

Furthermore, paperwork, red tape issues, and no-show rates are frequently cited by dentists as reasons for not participating in Medicaid.

Oral health care for children in Maryland Medicaid continues to be inadequate. Part of this inadequacy may be the result of reporting efforts that may mask the severity of access issues. Inaccurate reporting frustrates parents and health care workers seeking care for their children and adversely affects decisions of policymakers.

In summary, oral health care in Maryland Medicaid needs improvement and closer scrutiny as children with untreated dental problems continue to suffer from pain and infection and morbidity.

Thank you for your attention and for your interest in oral health care for poor children.

[The prepared statement of Dr. Tinanoff follows:]

ORAL HEALTH FOR UNDERSERVED CHILDREN IN MARYLAND

TESTIMONY BY

NORMAN TINANOFF, MARYLAND PEDIATRIC DENTIST

May 2, 2007

To

The Subcommittee on Domestic Policy
Committee on Oversight and Government Reform

Chairman Kucinich, Congressman Issa and members of the Subcommittee on Domestic Policy, thank you for inviting me here today to discuss the issues of oral health care for poor children, especially the situation in Maryland. I would like to give you my perspective on how in one of the richest states in the country, Medicaid can fail some of our most vulnerable children, as evidenced by the recent tragic death of a child due to a dental infection. Furthermore, I would like to suggest improvements in reporting, oversight, and policy that will make Medicaid oral health care in Maryland, and perhaps many other states more functional and effective.

In 1997 access to oral health care services for Maryland's poor children was the worst in the country. At that time, only 19% of children in the Maryland's Medicaid program had at least one dental visit each year and only 7% received restorative (treatment) services. There has been incremental progress made, primarily through the enactment of Maryland State legislation championed by key legislators and promoted by oral health advocates and organized dentistry in the State. This includes legislation that mandated utilization targets and reporting, loan assistance repayment programs for dentists who agree to treat Medicaid children, programs to facilitate foreign-trained dentists to serve as Pediatric Dental Fellows who treat Medicaid children, and budget bill language that increased 11 selected dental restorative (treatment) fees.

However, much more progress is needed in Maryland to properly address oral health care services for poor children. It is estimated that 50% of children covered by Medicaid in Maryland have cavities with only a small portion of these children receiving necessary restorative care. Consequently, many children still suffer from pain and infection from oral conditions, adversely affecting learning and behavior. Parents and health care workers continue to struggle to find dental providers to get the needed reparative services for these children.

The Maryland Legislature in 1998 required Maryland's Department of Health and Mental Hygiene (DHMH) to submit annual reports on "Dental Care Access" to the Maryland General Assembly. The October 2006 report covers topics such as: (1) Number of participating dentists; (2) Community clinic dental providers; and (3) Number of children and adults receiving dental services. Additionally, quality of Managed Care Organizations (MCO) services is measured by several DHMH reports: Consumer Assessment of Healthcare Providers and Systems-2006, Hedis-2006, External Quality Review Organization Report-2005 and Value-Based Purchasing

Activities Report-2005. Below is my analysis of some of the access to oral health care issues in Maryland, compared to these reports:

Providers

The DHMH October 2006 report to the Maryland General Assembly lists 918 unduplicated Medicaid providers as of July 2006 which is up from that reported in July 2005 by nearly 600 providers. The report ascribes the increase to "an information systems data clean-up. A footnote also states that, "Some dentists may not be accepting new referrals and many dentists limit the number of new referrals that they accept". Further, the number of dental Medicaid providers on DHMH's web site is 1,483 which includes 88 Washington, D.C. providers. A cursory glance of the provider lists on the web site shows numerous duplicate dentists, dentists who no longer practice, dentists who have moved, and deceased dentists. I was surprised that I was listed as a dental provider in Western Maryland, even though I only practice in Baltimore.

A more realistic calculation of the actual providers may be generated from direct calling of those dentists on the provider list to ask the question, "Will you take a new Medicaid patient", or by contacting county oral health officers for their knowledge of those dentists that will take a new Medicaid patient. Using this method the following information was obtained from 748 of the listed 918 unduplicated providers, derived from 19 of the 23 counties and Baltimore City located in Maryland:

County *	**# willing to take a new Medicaid patient**	**Unduplicated providers on DHMH list**
Charles	0	13
Calvert	1	10
Frederick	4	32
Prince George's	46	235
Allegany	2	23
St Mary's	9	21
Wicomico	10	20
Caroline	4	9
Cecil	1	7
Kent	1	4
Queeen Anne's	4	8
Wicomico	9	25
Worcester	2	8
Howard	10	62
Somerset	2	11
Talbot	1	4
Dorchester	1	8
Carroll	6	25
Baltimore County	57	223
Totals	170	748

*19 of 23 counties and Baltimore City that are located in Maryland

This shows that there is perhaps only one fifth of the actual number of listed Medicaid providers who will see a new patient. The discrepancy regarding the listed providers and those who are willing to take a child enrolled in Medicaid as a new patient is incredibly frustrating to patients and health care workers who seek care for these children.

The October 2006 DHMH report also lists Community Clinic Dental Providers. The numbers of public health clinics in Maryland is critical because it is believed that they provide the vast majority of oral health services. The report correctly states that there are only 12 of the 24 local health departments in Maryland that offer oral health services. However, there may only be nine, not 13 Federally Qualified Health Centers (FQHCs), with oral health services, with one of these sites having only a part-time dentist.

Number of Children in Medicaid, Dental Services Rendered and Children/Enrollee Ratio

The DHMH 2006 report lists the number of children receiving dental services, counting only those children ages 4-20, who have been enrolled for at least 320 days. However, the April 2005 report of the National Oral Health Policy Center mandates that States use Form 416, which requires counting total eligible children.

The table below compares for 2005 the number of children enrolled in Medicaid and the percent receiving any dental service as reported by Maryland's DHMH and as reported on CMS's Form 416. Additionally, the last column shows the ratio of dental providers to enrollee for 2006 as reported by DHMH, i.e., 1 dentist for every 439 children. Yet, if one uses the total eligible children (Form 416) per the number of providers (those willing to accept a new patient), the ratio would be far less, at about 1 dentist for every 2,500 children, exceeding the ratio of 1:2,000 as required by Maryland law.

Method of Counting Children	Total # of Enrollees	% Receiving Any Service	Children/Enrollee ratio
Children Ages 4-20 Enrolled over 320 days	227,572	45.8%	1:434
Total Eligible Children (Form 416)	501,807	30.7%	~1:2,500

Furthermore, DHMH continues to emphasize "percent receiving (any) service" as an indicator of access to care. A better indicator may be whether a child is receiving any restorative (treatment) service. In Maryland in 2005 only 15.8% of Medicaid children received a treatment service, as reported by DHMH. However, if the total of eligible children was used as derived from

Form 416, the number of children receiving restorative dental services would be 13.0%, ranking Maryland eight from the bottom of the 35 states reporting this information in 2005.

Quality Measures of Oral Health Care in Maryland Medicaid

In 2001 DHMH conducted town meetings to assess issues regarding the Medicaid system. Although these meetings concerned the total health care system, reports from those who attended these meeting indicated that most of the discussions focused on lack of access to oral health care. In the one session that I attended, the only issue that was discussed was the problem of access to oral health care. However, of the four quality reports published by DHMH in 2005-2006, only 1 of the 118 pages of reports addresses a dental issues. For instance the Consumer Assessment of Healthcare Providers and Systems-2006 survey has no consumer questions specific to oral health care or dentistry.

It is difficult to appreciate why these reports does not include oral health care, since access to oral health has been a continuing concern in Maryland for so many years. In any case, surveys may not be the best way to understand the problems of quality of oral health care in Maryland Medicaid. Perhaps a better approach would be to use regional focus groups to elicit much more specific information regarding parents' and health care workers' satisfaction with oral health services in Medicaid. Such focus groups would be a good follow up to the earlier town meetings.

Reimbursement Rates for Dental Procedures

Although the reimbursement rates for 12 selected restorative procedures were increased in 2003, most of the rates for procedures still are far below what a dentist would accept. The American Dental Association Survey of March 2004 ranks Maryland as 39 out of 50 states regarding reimbursement rates for diagnostic and preventive procedures. Incredibly, this report is lists Maryland as the worst state in the country for reimbursement rates for restorative procedures.

An illustration of the problem is the current reimbursement rate for dental sealants. Maryland Medicaid pays $9 per sealant, whereas the 50th percentile for dentists' fees in Maryland for a sealant is $40. In addition, Medicaid restricts this procedure to only a few teeth and will not pay for sealants on any primary tooth or any permanent premolar.

It is unreasonable to expect a high number of dentists to participate in Medicaid when the rates do not cover overhead costs and do not equal an acceptable discount rate, at perhaps 20-25%, for dentist participation. Furthermore, paperwork, red tape issues, and "no-shows" are frequently cited by dentists as reasons for not participating in Medicaid.

Summary

Oral health care for children in Maryland Medicaid continues to be inadequate despite some successful State legislative efforts championed by some key legislators with support from advocacy groups. Part of this inadequacy may be the result of reporting efforts that mask the severity of the access issues. Inaccurate reporting not only frustrates parents and health care workers seeking care for children, but the understatement of the problems adversely affects decisions of policy makers. The net result is that oral health care in Maryland Medicaid needs closer scrutiny and much more improvement as children with untreated dental problems suffer from pain, infection and morbidity and have related behavioral and learning problems.

How to Solve Dental Access Issues

- Recognize that oral health is critical to the overall general health of our children.
- State Medicaid managed care programs need more oversight and accountability. Uninterested third parties should evaluate the performance of oral health programs that serve Medicaid enrollees.
- State Medicaid programs need to be encouraged to work with oral health advocate to strengthen and improve programs and services.
- State Medicaid programs need to publish accurate data that it is helpful to case managers and patients who are seeking care, as well as to program administrators and policy makers.
- Reimbursement rates for dental procedures need to be adjusted to be consistent with commercial PPO schedules.
- Better case management and ease of paperwork is needed to increase dental provider networks.
- A public health infrastructure is needed to provide a geographically distributed backbone of oral health services. Maryland, similar to other states, needs the necessary resources to expand its oral health safety net system.

Mr. KUCINICH. Thank you, Dr. Tinanoff, Dr. Clark, Ms. Norris. We are now going to proceed with questions from Members of Congress.

I would like to begin with Ms. Norris. In your practice have you heard from other patients of Medicaid eligible children who have trouble finding dental care for their children?

Ms. NORRIS. Yes, Mr. Chairman, I have heard from quite a few families that have had trouble finding dental care. They complain that the provider lists are inaccurate. They complain that they have to call many, many dentists before they find one who is either contracted or will accept a new patient. They complain of having to wait many months for an appointment. Sometimes they have to drive very long distances to see a dentist, sometimes more than an hour, sometimes across the Bay Bridge. We have strange geography in Maryland and we have part of our State that isn't really connected to the rest of the State. I even had one family tell me that they had an appointment and they drove an hour-and-a-half to get to the appointment and they were turned away at the door with no explanation.

So I have heard many, many stories from many parents, and this is really an endemic problem.

Mr. KUCINICH. The information I presented at the beginning of this hearing, where I pointed out that the staff of this committee called 24 dentists, 23 numbers disconnected or incorrect, belonged to a dentist who did not take Medicaid patients, 24th didn't accept Medicaid patients or did accept but only for oral surgery, not general dentistry, and that effectively none of the 24 numbers listed would have been any use to Deamonte. Do you find this consistent with your own experience?

Ms. NORRIS. Yes, very much so. The dental provider lists are absolutely unreliable.

Mr. KUCINICH. Now, given your understanding, Ms. Norris, of why Medicaid eligible children have not been able to access adequate and appropriate dental care and Medicaid, what changes would you recommend?

Ms. NORRIS. Well, the first thing is, as I mentioned before, the tolerance of the gross under-performance of the State agencies. I think that if CMS were to exercise its statutory right to sanction States financially for failing to perform in this area, that would light a fire under the States and encourage them to reform.

Mr. KUCINICH. So we are talking in terms of increased oversight by CMS of dental access in State Medicaid programs?

Ms. NORRIS. Absolutely. Yes, Mr. Chairman, that is absolutely critical to fixing this problem.

Mr. KUCINICH. Thank you very much.

Dr. Clark, you mentioned that in order to see Medicaid patients a dentist must be willing to subsidize the patient's treatment. Why is that the case, and why do you think reimbursement rates for dentists are so low?

Dr. CLARK. Well, I think that if you are going to be treating a population of people as large as we have in Prince George's County, that you are invariably going to run across children who don't have access to care, and you are not going to be compensated at the rate that you would with patients who have insurance or pay out of

pocket. So basically what goes on is, as was mentioned, they are paying between 20 and 25 cents on the dollar. So any time you take any number of patients under Medicaid that you are treating, you are going to be subsidizing their care, based on the fact that there are other patients who pay for their services.

Mr. KUCINICH. So why do you think the reimbursement rates are so low? I mean, your experience is probably similar to others, except that you make sure these kids receive help.

Dr. CLARK. Well, traditionally the Medicaid reimbursement rates have been low, even before managed care got involved with the process, so there has never been an effort on the parts of those who fund dentistry for Medicaid or for under-served populations to actually pay the cost of what the service truly is. I think part of that comes from the fact that there is not a participation by the dental community to help aid in setting fees that is being listened to by those who have control over that.

Mr. KUCINICH. Thank you.

Dr. Tinanoff, you explained that you obtained your data from making individual calls to dentists in Maryland. Have you ever requested the same data from the State Medicaid agency to avoid the trouble of making all those calls? And what type of response did you get for your request for data?

Dr. TINANOFF. I specifically didn't ask them to do that type of analysis, but for some time I have been trying to work with them to try to solve some of these issues by collecting data. Not until just very recently, maybe in the last week, was I given new data that will help us analyze and understand the situation much better in Maryland.

I think that Maryland Medicaid would benefit greatly by working with people outside their agency to analyze their data and help them to analyze the problem. Part of the problem that we see here is that the data that is being presented to policymakers and legislators is presented in a way that doesn't excite legislators to put any more money into the budget. Currently, the dental component of the Maryland Medicaid budget is only 1 percent.

Mr. KUCINICH. Thank you, Doctor. I just was informed by staff that you did receive data this week from Maryland; is that right?

Dr. TINANOFF. Yes.

Mr. KUCINICH. OK. The Chair will recognize Mr. Cummings. Again, Mr. Cummings, this subcommittee owes you a debt of gratitude for not just calling this to our attention but for urging this hearing today. I was more than happy to comply. Please proceed.

Mr. CUMMINGS. Thank you very much.

I want to just pick up where the chairman left off. The data that you received, what did that data say?

Dr. TINANOFF. Excuse me?

Mr. CUMMINGS. He just asked you about some data that you just received this week. What did the data say?

Dr. TINANOFF. I haven't had a chance to analyze it because it is an enormous amount of data. It breaks down all the procedures by all the different types of dental procedures versus age, so it is pages and pages of data. It will take me some time to understand it.

Mr. CUMMINGS. Would you provide us with your conclusions at that point where you are able to come to some, please?

Dr. TINANOFF. I would be happy to.

Mr. CUMMINGS. I want to just thank you very much, chairman.

I want to go to you, Ms. Norris, and, as you know, Federal law mandates that every Medicaid eligible child will have access to medically necessary dental care under the early periodic screening diagnostic and treatment or EPSDT provision. What is your assessment of that provision and how it is carried out?

Ms. NORRIS. Well, the provision——

Mr. CUMMINGS. So that means that every child should be able to get treatment.

Ms. NORRIS. Well, each State sets its own dental periodicity schedule, and what that means is each State is required to say how frequently a child is supposed to get dental care and at what age they are supposed to begin.

Maryland does have a periodicity schedule that starts at age 1 and provides for 6-month visits every year up until age 20.

Mr. CUMMINGS. So you are saying that a child in Maryland should be getting some type of dental screening starting at age 1?

Ms. NORRIS. Yes.

Mr. CUMMINGS. All right.

Ms. NORRIS. It looks good on paper. The problem is that periodicity schedule exists in the pediatrician's section of the manual, and the pediatricians don't do this work. There is no requirement for dentists to actually do this work and there is no oversight of whether dentists have actually done this work, so nobody is doing it, and nobody is noticing that nobody is doing it.

Mr. CUMMINGS. That is deep. So, in other words, you have a provision and everybody is either assuming that they are not doing it or that they are doing it and nobody is doing it?

Ms. NORRIS. Nobody is doing it. Part of the reason why nobody is doing it is nobody is looking to see if anybody is doing it, and another reason is because we don't have the dentists. We don't have sufficient dentists willing to see these children.

Mr. CUMMINGS. So, going back to this EPSDT provision, the breakdown then is not with the law and the way it is written, but is, rather, with the implementation; is that correct?

Ms. NORRIS. Enforcement and implementation. Absolutely right.

Mr. CUMMINGS. And what is the best situation for oversight? I mean, I am sure you have thought about this many times, and if we could give you the magic wand and say how would you deal with oversight of this, and I am assuming that oversight you think would go a long way as long as there were sanctions connected with the oversight, what would your wish be?

Ms. NORRIS. Well, I think we need to actually look at whether care is provided to individual children according to the EPSD schedule. We need to collect data about that, which we are not doing right now. We are just collecting data about whether a child saw a dentist this year. So it is not nearly detailed enough.

We are also not looking at the oral health status that children are achieving through getting all this dental care that they are not getting.

I think that CMS needs to change its data collection and they need to require dentists to participate in the EPSDT reporting, not just pediatricians.

Mr. CUMMINGS. Do you think the Centers for Medicaid and Medicare Services are doing what they are supposed to do under the law? And you might want to answer this too, Dr. Tinanoff. You can go first.

Dr. TINANOFF. Part of the thing that is being reported to CMS is total number of visits, total number of preventive visits and restorative visits. Not all the States are actually doing those reports on a yearly basis. I think it is somewhere around 35 of the States are reporting out of the 50 States. One thing that is being emphasized, both at the State level and at the Federal level, is whether a child has seen a dentist in the past year. I don't know if that is the best indicator, because in Maryland, for instance, DHMH reports 45 percent of the children see a dentist, but the actual number of children that are getting care, restorative care, is probably close to 13 percent, according to CMS's form 416.

Mr. CUMMINGS. I am going to come back to you. I see my time is running out. I do want to ask this question, though. Dr. Clark and Dr. Tinanoff, I understand that less than one-half of 1 percent of all Medicaid spending goes to provide dental coverage. Is that your understanding? And if that is true, do you think that is sufficient.

Dr. TINANOFF. It is less than 1 percent.

Mr. CUMMINGS. It is less than 1 percent. Let's go with 1 percent. That is fine.

Ms. NORRIS. OK. Nationwide, dental Medicaid is about 5 percent. In the public sector, with regard to health care, 25 percent of health care for children is spent in dentistry. So you can see that Medicaid is insufficient, and in Maryland dental care is very insufficient with regard to funding.

Mr. CUMMINGS. And these are probably the folks that need it the most.

Dr. TINANOFF. That need it the most.

Mr. KUCINICH. Mr. Cummings brings up an important point, and I would just respectfully suggest to the members of this subcommittee that a followup to this meeting would be a discussion, a meeting with Medicare or Medicaid to talk about the role of dental care in overall health and how they may have to start dramatically appreciating the amount of money that is spent for dental care, because, as medical science understands, there is a closer relationship to dental health than to general health and maybe what previously thought when these guidelines were first adopted.

The Chair recognizes the gentlelady from California, Congresswoman Watson. Thank you.

We have been joined by the gentleman from Maryland, Mr. Wynn. Thank you.

Ms. WATSON. Mr. Chairperson, I want to thank you for holding this hearing. The timing is so right to look at the policy.

What is troubling to me is that we are setting up systems that are so dysfunctional, and you can see it when we have a tragedy like the one we have been talking about this afternoon. We build a bureaucracy that attempts to thwart the consumer and the pa-

tient from getting services. And why is that? Because they feel in these programs, the Medicaid program and others, that they do not get reimbursed enough.

I could go on all afternoon, Mr. Chairman, with another issue that has to do with dentistry, but I am going to stick on this one.

We are finding that the ratio of patients to providers is unacceptable. We are finding that students at the medical school are not going into dentistry because they don't want to get into a profession where they cannot get reimbursed properly.

And then I was just thinking, I think all of our universities that have medical schools ought to have emergency dental care, and then we would never have to have the kind of tragic situation that happened with Deamonte.

So I guess my question goes to the panel. And there are two other panels, Mr. Chairman?

Mr. KUCINICH. Yes, the gentlelady is correct.

Ms. WATSON. Because I want to get into the use of mercury. You knew that was coming, dental amalgams. I have to get into that, because that goes along with the lower socio-economic groups and the inexpensive cost of that one.

But panelists, how would you like to see us improve on the provisions of services through CMA so we will never have these tragedies reported to us again? And is that Dr. Tinanoff? Yes, we will start with you.

Dr. TINANOFF. There are many things that need to be improved, and it is a complicated question. There are Congressmen and Senators that are working on legislation as we speak. But for sure dentistry in Medicaid in Maryland and across the country is underfunded. That is the first and most important step. There are many other steps that need to be done, but that has to be addressed first.

Ms. WATSON. Sometimes you know the answers when you throw these questions out.

Dr. Clark.

Dr. CLARK. Yes. I think that there is a breakdown in communication between the legislature of various States and funding for Medicaid programs. My understanding is that the State of Maryland's dental budget is about $63 million. Of that $63 million, we don't know how much actually gets to the treatment end, and that is what needs to be established.

How much is required for administrative costs versus how much is required for treatment? I think that if $63 million is not enough, then that needs to be expressed to our legislators to let them know, and I think the managed care organizations have a role to say if it is not enough money, to encourage them and say well, our budget needs to be better than 1 percent of the overall Medicaid budget.

Ms. WATSON. All right. Ms. Norris, do you know if there is a cap? Let's just use Maryland, since we are starting there. Is there a cap on the cost of the overhead to provide services?

Ms. NORRIS. Yes. In Maryland I believe it is 15 percent for overhead and 2 percent for profit.

Ms. WATSON. Would adjusting that cap downward help this, or would we put all the dentists out of business?

Ms. NORRIS. Well, the dentists are not in the business of providing care to Medicaid children yet, but I don't think by adjusting the

15 percent administrative cost we would put the health plans out of business. We certainly would not. I think that is one place to start.

I also think in Maryland there are two layers. There is the health plan and then there is the subcontracted dental plan, so there are two sets of administrative costs in Maryland. I don't know if that is true in other States. I would make two other recommendations, in addition to more money. I think more money will help us get dental homes for all these children. All these children need to have assigned primary care dentists so that they don't have to go through this red tape of finding a contracted dentist.

The other thing I would recommend—and this I think might be able to come from the Centers for Disease Control—we need to have a nationwide high-profile public education campaign concerning the importance of getting children into early dental care so that the preventive end can be taken care of. I think even parents don't understand the importance of dental care to their children. I think that needs to be addressed at a national level.

Ms. WATSON. Thank you so much.

Thank you, Mr. Chairman.

Mr. KUCINICH. I think that is a very valuable suggestion and one that this subcommittee is going to certainly be instrumental in promoting in followup to this hearing.

Ms. NORRIS. Thank you.

Mr. KUCINICH. The gentleman from Chicago, Mr. Davis, has long been active in a range of issues relating to the children of the inner city. Congressman Davis, you are recognized.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. Let me apologize to the panelists because I didn't hear all of their testimony because I was engaged in some HeadStart activity. That still deals with children.

Let me thank you, Mr. Chairman, for calling the hearing, and also let me just ask if I might have unanimous consent to put into the record an opening statement that I had prepared, as well as a document, Access to Dental Care for Low Income Children in Illinois.

Mr. KUCINICH. Without objection, so ordered.

[The prepared statement of Hon. Danny K. Davis follows:]

OPENING STATEMENT
CONGRESSMAN DANNY K. DAVIS
DOMESTIC POLICY SUBCOMMITTEE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
"EVALUATING PEDIATRIC DENTAL CARE UNDER MEDICAID"
2154 RAYBURN HOB- 2:00 P.M.
WEDNESDAY, MAY 2, 2007

Thank you Chairman Kucinich and Ranking Member Issa for holding today's hearing aimed at evaluating the quality of pediatric dental care under Medicaid. We're here today as the result of the untimely death of Deamonte Driver, a twelve year-old Medicaid eligible boy, who died of a brain infection caused by tooth decay, a common childhood disease.

In examining the circumstances leading up to Deamonte's death, we must ask ourselves a series of questions pertaining to accessibility and accountability. Specifically:

Were health care resources available and accessible?
Did Deamonte receive early and periodic screening, diagnostic and treatment ("EPSDT")?
Did the service provider meet reasonable standards of dental practice as prescribed in Section 1905(r) (3) of the Social Security Act? And above all else
Did Federal Centers for Medicare & Medicaid Services (CMS) exercise due diligence in monitoring and evaluating the quality of services (performances) of state-run Medicaid programs?

Answers to these questions are vital in determining the condition of Medicaid programs servicing individuals and families with low incomes and resources. Among the groups of people served by Medicaid are eligible low-income parents, children, seniors, and people with disabilities. In 2002, Medicaid enrollees numbered

39.9 million Americans, the largest group being children (18.4 million or 46%).(hhttp://www.cms.hhs.gov)

In the last seven years, national attention has focused on the problem of limited access to oral health care for low-income children. Oral health disease has been called a "hidden epidemic." (DHHS, 2000 Report) Indeed, findings from a 2000 three-part study analyzing: 1) the quality of services; 2) dental care expenditures and dental care utilized by children enrolled in the Illinois Medicaid program; and 3) steps taken by Illinois—and six surrounding states—to address the problems of low access to dental care for children with Medicaid revealed:

Statewide, 33% (271,152) of children enrolled in Medicaid or KidCare utilized dental care from March 1999 through February 2000. Illinois children in the 4-5 and 6-12 year-old age groups had the highest proportion (about 50%). The very young children (under three years of age) and adolescents had lower utilization rates. While 38% of enrolled children in Cook County visited a dentist, the remainder of the State was below 30%.

34% (2,034) of active general and pediatric dentist were enrolled in Medicaid. Of enrolled dentist, 25% did not participate at all during the year, 39% submitted 1-100 services, 28% submitted 101-999 services, and 8% submitted 1,000 services or more.

The population-to-dentist ratios can be interpreted to mean each of the 2,034 enrolled dentists would need to treat 229 children, or each of the 1,537 participating dentists would need to treat 304 children. During the time period in question, only 165 dentists provided at least 1,000 services for the year (treating an estimated 185 children at an average of 5.4 services per dental service user).

The regional variation in both Medicaid children's utilization and enrollment and participation of dentists underscores the

> importance of examining access and workforce issues at small geographic levels.
> All seven Midwest states have untaken a number of initiatives including changes in state program and policies focused on increasing private practice dentist participation. However, in spite of the numerous and varied measures taken by these states, all seven states reported on-going problems with access to oral health care for low-income children. (Illinois Center for Health Workforce Studies, 2000)

Findings suggest that although oral health in the State of Illinois is improving, a segment of society has been left behind. People with low incomes, minorities, immigrants and people in rural areas have the greatest difficulty accessing care and maintaining good oral health. Quite frankly, this scenario isn't confined to just the Midwest, but the country at-large. Nationally, 20.7% of poor white children have untreated dental caries in comparison to non-Hispanic black children, which accounts for 43.6% and poor Mexican-American children whose needs are greatest (47.2%).

By all accounts, today's hearing has relevant policy implications, because not only does it put a name—Deamonte Driver—to statistics forewarning untreated dental caries, but calls for greater CMS oversight. With this in mind, I welcome distinguish guest panelists' insight and recommendations as to how we can improve access to oral health care and, significantly, improve oversight of pediatric dental care in Medicaid.

I ASK PERMISSION FROM THE CHAIR TO SUBMIT FOR THE RECORD DOCUMENTS FROM THE ILLINOIS CENTER FOR HEALTH WORKFORCE STUDIES FOR "ACCESS TO DENTAL CARE FOR LOW-INCOME CHILDREN IN ILLINOIS" AND THE NATIONAL ACADEMY FOR STATE HEALTH POLICY HIGHLIGHTING BARRIERS TO ACCESS AND

Mr. DAVIS OF ILLINOIS. Thank you very much.

It has been my contention for a long time that dental health was actually the step-child of health care delivery. I think that is a fundamental premise, and I think that is where we really have to begin and start from when we look at it.

I have always been fascinated because I couldn't quite understand it whether or not people were saying that dental health was not as important as physical health or mental health, although we don't do too well with mental health, either.

Would either of you venture an opinion as to why dentistry, dental health, has had such a low place in health care delivery?

Dr. TINANOFF. Maybe I could start, Congressman. Thank you for your interest in oral health care and your interest in HeadStart. I just want to give you a survey that we did at the University in 2001 regarding Maryland HeadStart children. We found that 45.6 percent of the 3-year olds in HeadStart had cavities, and many of these kids were in pain.

It escapes me why dentistry for these children is a step-child. Many of the kids that we see are in pain. We have a significant number that have infections. When Medicaid budgets are cut, dentistry seems like it is the first one that goes.

Mr. DAVIS OF ILLINOIS. Of course, I have never felt that Medicaid adequately funded anything, quite frankly, in terms of maybe some services for some professionals, but certainly not hospital care. I mean, it certainly does not do that.

Dr. Clark, would you care to comment?

Dr. CLARK. Yes. My perspective on why dentistry does not have a high priority is that we haven't adequately gotten the message across to the general public that dentistry is very important. My perception is that the biggest concern that people have is that they don't need to see a dentist because there is a continual lack of perceived need. In other words, if you don't have pain, you don't have bleeding, if you don't have presence of infection which is noticeable, there is generally, amongst most people, not a need to seek the treatment of a dentist.

I think that if we were to engage in public health initiatives that involved public service announcements, commercials, and education about dentistry, if we were to listen to what is coming from organized dentistry about how we need to approach educating people, in general, about dentistry—I don't mean just in Maryland, I mean in the United States and in the whole world—the attitude would change. But as it is right now, a lot of information concerning dentistry is never disseminated to the public unless you go to a dentist, because the information that we primarily get comes from the toothpaste manufacturers and manufacturers of mouthwashes. They will tell you to brush and floss and see your dentist and you are going to be fine.

But I always say to people, I say if you brush and floss and you see the dentist, people still manage to get toothaches, they still manage to loose teeth, they still manage to get dentures and have root canals. So obviously there is a disease process going on which is silent, which most people are not aware of it and we are not educating them. I think that is where we need to go to start to begin to educate people that not treating these disease conditions can

cause much worse problems, it can cause what happened with Deamonte Driver, it can cause problems related to heart disease and stroke, it can cause all kinds of deleterious health effects, but we are not communicating that to the general public.

Mr. DAVIS OF ILLINOIS. So education is the key.

Ms. Norris, could I ask you, I mean, I have always been intrigued also by the EPSDT that most of the emphasis seems to have been on the EPSD and virtually none on the T. I am saying many people seem to act as though the T is not there. I am saying States seem to act as though the T is not there. People who do the screening and detection seem to act as though the T is not there. And oftentimes the recipients don't really know that they can push the T. How do we overcome that?

Ms. NORRIS. The T is the expensive part.

Mr. DAVIS OF ILLINOIS. Yes.

Ms. NORRIS. That is the treatment. Very often the people who do the screening and the diagnosis are not the same people who have to do the treatment, so that involves a referral. We also do a better job, I think, of tracking whether the screenings are being done. We don't collect as much data as religiously concerning the T. We don't watch that. I think that could help a lot if we cared about whether the T happened and we put enough money into this system to guarantee that the treatment could take place.

Mr. DAVIS OF ILLINOIS. Well, thank you very much. Mr. Chairman, I assure you if this committee can just do something about this one issue over the next 2 years, it will have been worth its weight in gold. Thank you very much for calling this hearing. I thank the witnesses.

Mr. KUCINICH. And I want to thank Congressman Davis for saying that, because I think we have the composition of this committee and experience on this committee to be able to make a major impact on this issue, and certainly this testimony today provides us with incentive.

When you look at the picture of that beautiful boy there, when you look at his face and you can see that maybe there was a doctor there, maybe there was a lawyer there, maybe there was a legislative leader, future Member of Congress, a life that was cut short, you really realize how serious our responsibilities are to make sure that the Deamontes of the world who are out there who you, Dr. Clark, have been dedicated to treating, and you, Dr. Tinanoff, have been dedicated, and you, Ms. Norris, make sure they have access. I mean, we really go deeply into this, so this is a good subcommittee to do that.

The Chair wants to recognize the gentleman from Maryland, Mr. Wynn, for purposes of a statement and questions as a followup.

Mr. WYNN. Well, thank you very much, Mr. Chairman. First, let me commend you for holding this hearing and thank you for your kindness and generosity in allowing me to participate.

I also want to thank the witnesses for coming in. I apologize that prior commitments prevented me from hearing your testimony, although I have been briefed and I appreciate the contributions that you are making here today.

This young man is my constituent. This was a tragedy that devastated our community because it seems so needless, and people all

across the country were appalled to learn that a young man died from a problem that basically started with tooth decay, a problem that was preventable with access to adequate dental care, and a problem that shed light on a tremendous gap in the U.S. health care system.

Tooth decay is the most common disease among children, one of the most common diseases amongst children. I was amazed to find it is five times as common as asthma.

But what I was dismayed to find is that there are Medicaid hassles or administrative problems that seem to be a barrier to care. As a matter of fact, I heard from some dentists that they would rather give free care than have to work through the Medicaid system, which I think is a very telling statement.

I am working on a bill with the National Dental Association, the American Dental Association, the American Dental Education Association, the American Academy of Pediatric Dentistry to work to develop a bill that will remove some of these barriers. But I wanted to ask a couple of questions about some of the testimony and some of the views of the panelists here.

I believe, Ms. Norris, you said there was a cap on overhead of 15 percent. Do you consider that to be a fair cap or realistic or realistically calculated or realistically administered?

Ms. NORRIS. I think it is fairly typical. I don't think it is out of range of what most managed care organizations feel they need. I would certainly like to see less money go to administrative care. As I mentioned before, with the double layer of the health plan and the dental plan, I don't know how much of the money is sucked up in additional administrative costs because of that double layer.

Mr. WYNN. Would a lower cap reduce the number of physicians participating?

Ms. NORRIS. If the health plans had to spend more money on dental care and less money on administration, it would certainly help, because more money would be going to care for the Deamonte's of the world. Yes.

Mr. WYNN. Now, what about the 2 percent profit cap that you referred to? What is the impact of that? Should we increase it? How would that work?

What we are trying to get at is actually more access. What changes would help us with access?

Ms. NORRIS. Well, we need more money in the system, and 2 percent of $63 million is $1.2 million that is going directly to corporate profit and not going to dental care, so if there is any way we could reduce that amount, that would be terrific.

I also think we need to set our sights a little higher than just getting children into care once a year. I think we need to set our sights on achieving oral health for this population, and that would require a different set of performance measures, but I think we need to go there.

Mr. WYNN. Dr. Clark, you are a practitioner in the county that I represent. What is your view in terms of the Medicaid program and why so few—I believe the figure quoted was 46—why are so few dentists willing to participate in the Medicaid program?

Dr. CLARK. When you look at the overall expense of providing care, if you don't at least meet the number percentage-wise to cover

overhead, then you are operating at a deficit. At $0.25 on a dollar when you need $0.65 or $0.70 on a dollar is just not going to get it. You have to hire staff to treat people. You are doing a fee for service Medicaid plan, which means that for every dollar that you receive you are going to have to give treatment, which means you have to hire some staff person to pay them. So by the time you hire somebody, whatever money you receive, you are already operating in the red. So it is just not feasible to incorporate this into a private practice business.

Mr. WYNN. What about the administrative hassles?

Dr. CLARK. It is not just with managed care organizations, it is with any type of third party payer. When you submit a claim for treatment, there is no guarantee of payment. When you submit the claim, there are occasions when the claim is sent back to you. You may call and check on claims, and therein lies a big problem because you are dealing with an automated system, you are dealing with time consumed just to followup on getting paid, so a lot of people don't want to deal with the red tape of trying to followup on something for which there is very low compensation anyway, so it has inherent barriers just in administering the plan.

Mr. WYNN. I would like to ask the entire panel, I guess, one last question. Would you favor more school-based programs or school-linked programs as a way to provide greater access to care?

Dr. TINANOFF. Maybe I will start with that. There are so many kids in the system that are not getting care that school-based and school-linked may not be sufficient. You may not have sufficient providers. You really have to engage the private dental community and the public health sector, as well. One of the ways to do that is to increase the fees to a point where dentists will accept these fees, and if that is the case then you have a sufficient number of providers in the system. To get that, you probably have to have a discount rate of 20 to 30 percent of normal fees rather than where it is right now, where in this case Maryland is one of the lowest in the country, and that is the reason why there are so few providers that will accept the Medicaid rates.

Mr. WYNN. Actually, Deamonte's mother was relatively conscientious in some respects with regard to getting dental care. Would a school-based program help the children of less-conscientious parents?

Dr. TINANOFF. With a school-based program the kids will be there for sure, but there may be a great difficulty still to find dental providers, to find dentists that would work in the school systems, so it still may not relieve the problem.

Ms. NORRIS. If I may take a moment just to say that there are some preventive measures such as fluoride varnishes and sealants that may be able to be done in a school setting, maybe not cavity pulling and filling teeth, but there may be a specific role for dental care in the schools, but it would not cover the entire territory.

Mr. WYNN. What about screening in the schools? I know my time must be out. What about screening in a school-based program so that the school is at least able to identify potential problems and see what resources are available. Could that help the situation?

Dr. CLARK. A school-based program might be good in identifying the problem, but after you identify the problem you get right back

to the same situation of, how do you followup with treatment, and that is where the problem really lies.

Mr. WYNN. Thank you.

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman. Again, we are definitely going to do some followup in this subcommittee, and one of the things, as a result of your questioning, Mr. Wynn is, there has to be a connection also with diet, and school is not a bad place to start that discussion, as well.

So let's now move to our distinguished colleague, Mr. Shays from Connecticut. Thank you, Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. Mr. Chairman, sorry I missed the beginning of this hearing.

Mr. KUCINICH. We are glad to have you here. Thank you.

Mr. SHAYS. We served together as a team on the subcommittee on National Security, and I just think this is a great subcommittee for you, as well.

This is a very important issue. I don't have a question to ask, but I just want to say to start that in my State we rank at the very bottom, Connecticut, in reimbursement, so I have doctors that work on $0.20 on the dollar of what they would charge, and we have hardly anyone in the State that wants to help individuals receive Medicaid assistance.

It is beyond disgraceful. My State, frankly, it can't be a Republican or Democratic issue because it is a very strong legislative body that is Democratic and a Republican Governor.

I want to be on record as saying that I think there needs to be some type of percent. Is it 75 percent of whatever the market price is, 85, whatever, but it shouldn't be 20 percent.

I just would like to ask you, Dr. Clark, there was mentioned earlier in your testimony, in testimony, that appointments are broken. Is that because we are saying that clients are reluctant to use this service and they will make an appointment casually and not keep it? What is the problem?

Dr. CLARK. I think when you are dealing with people in socio-economic areas that may not have transportation by car, rely on public transportation or someone else to bring them to the dentist, and you also find this population that if you call to confirm appointments sometimes phone numbers have changed or they are using a cell phone as primary form of communication, it is just difficult to sometimes ascertain whether or not they are going to keep an appointment, even when you schedule it.

Mr. SHAYS. Isn't it the other issue, though, that if you let your teeth deteriorate so badly that you almost feel that the medicine kills the patient, I mean, talking about five teeth being pulled. I wouldn't want to make that appointment no matter what.

Dr. CLARK. There is a big problem with phobias and fear.

Mr. SHAYS. Well, that is a darn scary thing.

Dr. CLARK. Yes, that is true, and that is the way the general public thinks about it. I mean, ideally we would like to think that we could treat every patient in a setting where we could sedate them. This is just not realistic.

Mr. SHAYS. Right. But the point is, though, that patients don't really know.

Dr. CLARK. Right.

Mr. SHAYS. I have seen people that their teeth don't look in good condition and you want to say why don't you just go to a dentist, but if you have never really gone to a dentist your worst fears are what you think.

Dr. CLARK. Right.

Mr. SHAYS. And, frankly, there are things that I wouldn't want to do. I wouldn't want to get an MRI in a little tube. I don't know I'd say I would rather die first, but you are not getting me in that thing.

Dr. CLARK. I find patients don't want to get their teeth cleaned.

Mr. SHAYS. Yes.

Dr. CLARK. They just find dentistry obnoxious. So it is the nature of the beast. I mean, we have to deal with people who are fearful. We have to deal with children who are more fearful than adults are. So it is something we have to deal with.

Mr. SHAYS. Let me ask you, Ms. Norris, you handled and were an activist for the young man's family who passed away helping with another child.

Ms. NORRIS. Yes.

Dr. CLARK. I wasn't associated with that.

Mr. SHAYS. Ms. Norris.

Dr. CLARK. Sorry.

Ms. NORRIS. Yes.

Mr. SHAYS. Would you make an assessment that, when we are talking about health care, that you would rank up as one of the neglected areas dental care as one of the higher?

Ms. NORRIS. Most certainly. Most certainly. This system is close to impenetrable for low income parents. It is complex and there isn't, even when they puncture the red tape, there aren't any dentists at the other end. It is definitely a step-child of medical care and something needs to be done about it.

Mr. SHAYS. What I was told by the dentists, as well, is that just, for instance, cleaning teeth, they may end up paying $60 to their assistant, and in Connecticut they get $20.

Ms. NORRIS. Right.

Mr. SHAYS. So they literally are out of pocket. It is not their time being used.

Ms. NORRIS. Right.

Mr. SHAYS. It is literally out of pocket.

Ms. NORRIS. They are not only donating their own time that they do see the patient, but they are out of pocket. Absolutely. And we only have about 200 dentists in the entire State of Maryland who are willing to participate in that, and we have 500,000 children to treat, so it is just not working.

Mr. SHAYS. What is the overall statistic of dentists and participation? I am told it is only about 10 percent participate.

Ms. NORRIS. In Medicaid?

Mr. SHAYS. Yes.

Ms. NORRIS. Well, the State's numbers say 16 percent, but, as Dr. Tinanoff's survey shows, it is much less than that.

Mr. SHAYS. I'm sorry. That was covered before.

Ms. NORRIS. Yes.

Mr. SHAYS. Thank you all very much.

Mr. Chairman, I am really grateful you have had this hearing. A lot of work needs to be done. I know you will seek a solution on both sides of the aisle on this.

Mr. KUCINICH. Certainly we can rely on the gentleman from Connecticut, Mr. Shays, to participate in any of our efforts to seek a solution.

Before we discharge this panel and go on to the next, I want to take my prerogative as Chair to recognize a young advocate of health care for children who just happens to be right behind me. This is Ari Bourke, and Ari is here today on Capitol Hill advocating on a very important child health care issue. We wanted to welcome you and thank you for sitting in on this hearing, which is about children's health and, in particular, making sure that children have access to dental health.

Mr. SHAYS. If you would like, you can sit on this side of the aisle. We need as many recruits as possible.

Mr. KUCINICH. It is funny how they never fail to keep recruiting. We are so happy that you are here, Ari, and just wanted to let you know.

Did you want to say anything about health care for children?

Mr. BOURKE. No.

Mr. KUCINICH. OK. Well, we will be your voice today. Thank you so much. Please join me in thanking Ari for being with us today.

[Applause.]

Mr. KUCINICH. Once again, thanks to the first panel. Our staff will be in contact with you regarding followup on some of these issues as we continue to do the work of this subcommittee in assuring that children are going to have more access to dental health and that we look at the systemic issues that are brought forward by this panel and the work of the subcommittee.

On behalf of the subcommittee, we thank each of you for your attendance here, and we will now move to the second panel.

While the second panel is getting ready to come forward, this second panel will include the Director of Health Care for the Government Accountability Office and also the Director for the Director for Medicaid and State Operations in Health and Human Services.

I would ask staff if they could provide the appropriate name cards, and then we will begin.

I would seek unanimous consent to enter into the record documents that relate to managed care organization Health Choice, provider agreement, American Dental Education Association, an article on Protecting Children with Acute Care Dental Needs, and a memorandum to the House Committee on Oversight and Government Reform from Specialists in Social Education, Domestic Social Policy Division, CRS.

Without objection, so ordered.

Mr. WYNN. Mr. Chairman, could I also ask that my statement be included in the record?

Mr. KUCINICH. So ordered, without objection. The statement of Mr. Wynn is included. Thank you, sir.

Thank you very much. I would like to introduce panel two.

Dr. James Cosgrove is an Acting Director at the U.S. Government Accountability Office focused on health policy issues. During his tenure at GAO, Mr. Cosgrove has directed several studies on

Medicaid financing and policy topics, including States' restructuring of their Medicaid programs using 1115 waivers, use of competitive bidding to set Medicaid managed care premiums, and the implication of block grant financing for Medicaid.

In related health policy work at GAO, Mr. Cosgrove has led numerous studies on Medicare financing and policy topics that cover, among other things, managed care, physician services, and specialty hospitals.

Prior to joining GAO in 1989, Mr. Cosgrove was an assistant professor of economics at Marquette University.

Welcome, Dr. Cosgrove.

Next after Dr. Cosgrove we will hear from Dennis Smith. Mr. Smith is the Director of the Center for Medicaid and State Operations. In this capacity, he oversees Medicaid, the State Children's Health Insurance Program survey and certification, and the Clinical Laboratories Improvement Act. The Center also serves as the focal point for all CMS interactions with States and local governments.

Mr. Smith has been the director of CMSO since 2001, and prior to his appointment Mr. Smith served on the Bush-Cheney Transition Team as Chief Liaison to the U.S. Department of Health and Human Services and previously served as the director of the Department of Medical Assistance Services for the Commonwealth of Virginia.

We are, indeed, fortunate to have these two outstanding witnesses on our second panel.

To the witnesses, it is the policy of our Committee on Oversight and Government Reform to swear in all witnesses before they testify. I would ask that you would rise and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Let the record reflect that the witnesses answered in the affirmative.

As with the first panel, I ask each witness to give an oral summary of his testimony and to keep his summary under 5 minutes in duration, to bear in mind that your complete written statement will be included in the hearing record.

Dr. Cosgrove, thank you for being here. We will begin with you.

STATEMENTS OF JAMES COSGROVE, PH.D., DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND DENNIS SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS, HEALTH AND HUMAN SERVICES

STATEMENT OF JAMES COSGROVE

Mr. COSGROVE. Mr. Chairman, members of the subcommittee, I am pleased to be here as you discuss Medicaid's dental care for children. By virtue of their Medicaid eligibility, more than 30 million children from low-income families are entitled to receive both preventive dental care and treatment for dental disease. However, untreated tooth decay is much more common among children from low-income families than it is among children from higher-income families. And, as you have heard today, lack of timely dental treatment may have serious and sometimes tragic consequences.

Medicaid dental services are required under the early and periodic screening and diagnostic and treatment, or EPSDT, program. As the agency responsible for overseeing administration of States' Medicaid programs, CMS has an important role in ensuring that States comply with Federal requirements, including reporting requirements. My remarks today will describe the data that CMS requires States to submit on provision of dental services and discuss the extent to which these data are sufficient to inform CMS's oversight of States' programs.

My comments are based in part on relevant reports we published between 2000 and 2003. To the extent that we could in the time we had available before this hearing, we updated key findings by reviewing selected reports from CMS and researchers, and also interviewing officials from CMS, five State Medicaid programs, and several national health associations.

In brief, CMS annually collects State data for purposes of overseeing the delivery of dental and other required EPSDT services. States submit these data on a form known as the CMS 416, which captures State-level summary data such as number of Medicaid eligible children within a State to receive any dental service, a preventive dental service or dental treatment.

States are required to report information on all EPSDT dental services provided to children, regardless of whether those services are provided under fee-for-service arrangement or managed care arrangement.

We reported in 2001 and found again in 2007 that not all States submit the required CMS 416s on time or at all. We further reported that many CMS 416s were not accepted because they were incomplete or unreliable.

Currently, seven States have not submitted their 416s for fiscal year 2005, which were due to CMS more than a year ago, and two States have submitted reports considered to be deficient by CMS. We estimate that these nine States account for 20 percent of all children enrolled in Medicaid nationwide. This finding is, however, an improvement over what we reported in 2001. In that year we reported that CMS form 416s for fiscal year 1999 were missing or deficient for 30 States.

The problem goes beyond missing data, however, in 2001 we also reported that CMS 416 data were unreliable. According to the State and National Health Association officials we recently interviewed, the data have improved over time; however, many of these officials stated that data reliability problems remain. For example, they cite inconsistencies in how States report data and urge caution in using the data to compare one State to another. One official illustrated this point by saying that some States inappropriately include oral health assessments conducted by school nurses and other health professionals as dental exams.

In addition to data completeness and reliability issues, the type of data collected on the 416s limit their usefulness for program oversight.

Let me mention three key limitations. First, rates of dental services delivered to children in managed care cannot be identified distinct from fee for service. Second, the extent to which children have received the recommended number of visits cannot be determined.

And, finally, the data do not reveal the specific factors such as the availability of beneficiaries to find dentists to treat them, which may be responsible for the low use of dental services in a State.

In conclusion, I want to underscore the importance of good data for program oversight. Accountability starts with performance measures that are comprehensive, accurate, and transparent. Currently, the CMS 416s, while improved from prior years, fall far short of those standards. More work needs to be done so we can quickly identify problems, recognize and promote best practices, engage the progress of individual States in our Nation in meeting the oral health care needs of children from low-income families.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions you have, or members of the subcommittee.

[The prepared statement of Mr. Cosgrove follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Domestic Policy, Committee on Oversight and Government Reform, House of Representatives

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MEDICAID

Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services

Statement of James Cosgrove
Acting Director, Health Care

GAO-07-826T

May 2, 2007

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Highlights

Highlights of GAO 07-826T, a testimony before the Subcommittee on Domestic Policy, Committee on Oversight and Government Reform, House of Representatives

MEDICAID

Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services

Why GAO Did This Study

The 31 million children enrolled in Medicaid are particularly vulnerable to tooth decay, which, if untreated, may lead to more serious health conditions and, on rare occasion, result in death. Congress established a comprehensive health benefit for children enrolled in Medicaid to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which include dental services. The Centers for Medicare & Medicaid Services (CMS) is responsible for oversight of these services. States are responsible for administering their state Medicaid programs in accordance with federal requirements, including requirements to report certain data on the provision of EPSDT services.

GAO was asked to address the data that CMS requires states to submit on the provision of EPSDT dental services and the extent to which these data are sufficient for CMS oversight of the provision of these services.

This testimony is based on reports GAO issued from 2000 through 2003. GAO updated relevant portions of its earlier work through interviews conducted in April 2007 with officials from CMS; state Medicaid programs in California, Illinois, Minnesota, New York, and Washington (states contacted for GAO's 2001 study or referred to GAO by another official); and national health associations. GAO also reviewed relevant literature provided by officials from CMS and other organizations.

www.gao.gov/cgi-bin/getrpt?GAO-07-826T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact James Cosgrove at (202) 512-7118 or cosgrovej@gao.gov.

What GAO Found

CMS requires states to report annually on the provision of certain EPSDT dental services through form CMS 416. The CMS 416 is designed to provide information on state EPSDT programs in terms of the number of children who receive child health screening services, referrals for corrective treatment, and dental services from fee-for-service providers and under managed care plans. Data captured on dental services include the number of children receiving any services, any preventive services, and any treatment services.

The CMS 416s, however, are not sufficient for overseeing the provision of dental and other required EPSDT services in state Medicaid programs. We reported in 2001 that not all states submitted the required CMS 416s on time or at all. CMS 416s that states did submit were often based on incomplete and unreliable data. States faced challenges getting complete and accurate data, however, particularly for children in managed care. According to agency officials, CMS has taken steps since our 2001 report to improve the data. For example, CMS has conducted reviews of some states' EPSDT programs that included assessments of states' CMS 416 data. CMS officials said that 11 states' EPSDT programs had been reviewed since 2002. CMS has also required since 2002 that states collect data on utilization of dental and other required EPSDT services from managed care plans. State and national health association officials told us that these data have improved over time. But concerns about the CMS 416 remain. Concerns cited by state and national health association officials we contacted included inconsistencies in how states report data, data inaccuracies, and problems with the data captured that preclude calculating accurate rates of the provision of dental and other required EPSDT services. Further, the usefulness of the CMS 416 for federal oversight purposes is limited by the type of data currently requested. First, rates of dental services delivered to children in managed care cannot be identified from the data. Second, the data captured do not address whether children have received the recommended number of dental visits. And third, the data do not illuminate factors, such as the inability of beneficiaries to find dentists to treat them, which contribute to low use of dental services among Medicaid children.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you examine the Centers for Medicare & Medicaid Services' (CMS) oversight of dental care for the 31 million children from low-income families enrolled in the Medicaid program,[1] including the significant number of children covered by managed care. Medicaid is the joint federal-state program that provides health care coverage for certain low-income individuals. According to the Centers for Disease Control and Prevention, tooth decay is one of the most common chronic infectious diseases among U.S. children: 28 percent of children aged 2 to 5 have had decay in their primary (baby) teeth, about 50 percent by age 11. Untreated tooth decay may result in pain, dysfunction, and other problems that may lead to more serious health conditions and, on rare occasion, result in death. Low-income children—such as those enrolled in Medicaid—are estimated to be twice as likely to have untreated tooth decay as children in families with higher incomes.

In 1967, Congress established a comprehensive health benefit for children enrolled in Medicaid to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.[2] In 1989, Congress further defined EPSDT services to specifically include dental services.[3] As the agency responsible for overseeing the administration of states' Medicaid programs, CMS has an important role in ensuring that states comply with federal requirements, including that each state report annually to CMS on certain aspects of dental and other EPSDT services. Despite the known prevalence of tooth decay in the Medicaid population, recent CMS estimates of the provision of dental services, based on state reports to CMS, indicate that only about one-third of Medicaid children received a dental service in fiscal year 2005.

[1]Estimated enrollment for all children in Medicaid in fiscal year 2006.

[2]Social Security Amendments of 1967, Pub. L. No. 90-248, §302, 81 Stat. 821, 929 (1968) (codified, as amended, at 42 U.S.C. §1396d(a)(4)).

[3]Omnibus Budget Reconciliation Act of 1989 (OBRA), Pub. L. No. 101-239, § 6403(a), 103 Stat. 2106, 2262 (1989)(codified, as amended, at 42 U.S.C. §1396d(r)). EPSDT services include comprehensive, periodic evaluations of health, developmental, and nutritional status and dental, vision, and hearing services for individuals under age 21. EPSDT dental services must include dental services that are (1) provided at intervals that meet reasonable standards of dental practice; (2) provided at other intervals as medically necessary to determine the existence of a suspected illness or condition; and (3) include relief of pain and infections, restoration of teeth, and maintenance of dental health.

My remarks today will address the data that CMS requires states to submit on the provision of EPSDT dental services and the extent to which these data are sufficient for CMS oversight of the provision of EPSDT dental services for children enrolled in Medicaid. My testimony is based on reports we issued from 2000 through 2003,[4] an assessment of CMS's reporting requirements and state-submitted reports obtained from CMS in April 2007, and a review of selected CMS reports on EPSDT services and of related literature in April 2007. Our past work on the data CMS requires states to submit focused on the broad range of required EPSDT services, including dental services, but did not focus specifically on dental services data. We have supplemented these findings with information from our past work on oral health, including factors contributing to low use of dental services by low-income populations. We also updated relevant portions of our earlier information through interviews conducted in April 2007 with officials from CMS and state Medicaid programs in California, Illinois, Minnesota, New York, and Washington—states we contacted in our earlier work[5] or which were referred to us by an official from a national health association who considered the states' experiences to be relevant to our current work. We interviewed officials from national health associations, including the Children's Dental Health Project, Medicaid/SCHIP Dental Association, the National Academy of State Health Policy, the National Oral Health Policy Center, and the George Washington University Medical Center for Health Services Research and Policy. All of our work was conducted in accordance with generally accepted government auditing standards.

In summary, CMS collects annual data from states for purposes of overseeing the delivery of dental and other required EPSDT services. Each year, states must submit EPSDT reports known by the form on which they are submitted, the CMS form 416. The CMS 416 report (hereafter called the CMS 416) is designed to capture data such as the number of children who received any dental service, a dental preventive service, or a dental treatment service. CMS has indicated that the CMS 416 is used to assess

[4]*See Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care*, GAO-03-222 (Washington, D.C.: Jan. 14, 2003); *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001); and *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149 (Washington, D.C.: Sept. 11, 2000).

[5]For our 2001 study on federal government efforts to ensure state Medicaid programs provided covered EPSDT services, we contacted selected states, including Washington, and we visited California, Connecticut, Florida, New York, and Wisconsin. See GAO-01-749.

the effectiveness of state EPSDT programs to determine the number of children provided child health screening services, referred for corrective treatment, or receiving dental services.

The CMS 416s, however, are not sufficient for overseeing the provision of dental and other required EPSDT services in state Medicaid programs. We reported in 2001 that not all states submitted the required CMS 416s on time or at all. CMS 416s that states did submit were often based on incomplete and unreliable data. States faced challenges getting complete and accurate data, however, particularly for children in managed care. According to agency officials, CMS has taken steps since our 2001 report to improve the data. For example, CMS has conducted reviews of some states' EPSDT programs that included assessments of states' CMS 416 data. CMS officials said that 11 states' EPSDT programs had been reviewed since 2002. CMS has also required since 2002 that states collect data on utilization of dental and other required EPSDT services from managed care plans. State and national health association officials told us that these data have improved over time. But concerns about the CMS 416 remain. Concerns cited by state and national health association officials we contacted included inconsistencies in how states report data, data inaccuracies, and problems with the data captured that preclude calculating accurate rates of the provision of dental and other required EPSDT services. Further, the usefulness of the CMS 416 for federal oversight purposes is limited by the type of data currently requested. First, rates of dental services delivered to children in managed care cannot be identified from the data. Second, the data captured do not address whether children have received the recommended number of dental visits. And third, the data do not illuminate factors, such as the inability of beneficiaries to find dentists to treat them, which contribute to low use of dental services among Medicaid children.

We discussed the key findings of our testimony with CMS officials and obtained from them technical corrections, which we incorporated as appropriate. CMS commented on our earlier reports upon which our testimony is primarily based.[6]

[6]CMS generally agreed with the two related recommendations we made in 2001, that CMS work with states to improve EPSDT reporting and that CMS develop a mechanism for sharing model practices among states for providing EPSDT practices.

Background

Medicaid is one of the largest programs in federal and state budgets. In fiscal year 2005, the most recent year for which complete information is available, total Medicaid expenditures were an estimated $317 billion. The estimated federal share that year was about $182 billion. States pay qualified health providers for a broad range of covered services provided to Medicaid beneficiaries, and the federal government reimburses states for their share of these expenditures. The federal matching share of each state's Medicaid expenditures for services is determined by a formula defined under federal law and can range from 50 percent to 83 percent. Each state administers its Medicaid program in accordance with a state plan, which must be approved by CMS.[7] Medicaid is an open-ended entitlement program, under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under each state's federally approved Medicaid plan.

States have considerable flexibility in designing their Medicaid programs, including certain aspects of eligibility, covered services, and provider payment rates. But under federal law, states generally must meet certain requirements for what benefits are to be provided, who is eligible for the program, and how much these beneficiaries can be required to pay in sharing the cost of their care. States are required, for example, to cover certain services under their state plans, such as physician, hospital, and nursing facility services, as well as EPSDT services for beneficiaries under the age of 21.[8]

EPSDT Services

EPSDT services are designed to target health conditions and problems for which children are at risk, including obesity, lead poisoning, dental disease, and iron deficiency. EPSDT services are also intended to detect and correct conditions that can hinder a child's learning and development, such as vision and hearing problems. For many children, particularly those with special needs related to disabilities or chronic conditions, EPSDT services can help to identify the need for, and make available, essential medical and support services.

[7]In order to qualify for federal matching funds, a state plan must detail certain elements of a Medicaid program, including the populations served, the services the program covers, and the rates of and methods for calculating payments to providers. Any changes a state wishes to make to the state plan must be submitted to CMS for review and approval in the form of a state plan amendment.

[8]See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a).

State Medicaid programs are required to cover EPSDT services for Medicaid beneficiaries under 21.[9] These services are defined as screenings, which must include a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests (including a blood-lead assessment), and health education. Other required EPSDT services include

- dental services, which must include relief of pain and infections, restoration of teeth, and maintenance of dental health;
- vision services, including diagnosis and treatment for vision defects, and eyeglasses;
- hearing services, including diagnosis and treatment for hearing defects, and hearing aids; and
- services necessary to correct or ameliorate physical and mental illness discovered through screenings, regardless of whether these services are covered under the state's Medicaid plan for other beneficiaries.[10]

Although state Medicaid programs must cover EPSDT services, states have some flexibility in determining the frequency and timing of screenings, including the provision of dental services. Federal law requires states to provide dental services at intervals that meet reasonable standards of dental practice, and each state determines these intervals after consulting with recognized dental organizations.[11] Each state must also develop dental periodicity schedules, which contain age-specific timetables that identify when dental examinations should occur.

Medicaid Delivery and Financing

States generally provide Medicaid services through two service delivery and financing systems—fee-for-service and managed care. Under a fee-for-service model, states pay providers for each covered service for which they bill the state. Under a managed care model, states contract with managed care plans, such as health maintenance organizations, and prospectively pay the plans a fixed monthly fee, known as a capitated fee,

[9] 42 U.S.C. §1396d(a)(4)(B).

[10] See 42 U.S.C. §1396d(r).

[11] See 42 U.S.C. §1396d(r)(3)(A). State Medicaid programs, however, must also provide dental services whenever necessary to identify a suspected illness.

per Medicaid enrollee to provide or arrange for most medical services.[12] This model is intended to create an incentive for plans to provide preventive and primary care to reduce the chance that beneficiaries will require more expensive treatment services in the future. However, this model may also create a financial incentive to underserve or deny beneficiaries access to certain services.

State Medicaid agencies use a variety of delivery and payment approaches to provide dental services under Medicaid. These include (1) paying managed care plans with which they have contracts to cover or arrange for the provision of dental services; (2) "carving out" or not requiring the provision of dental services from the group of services provided by managed care plans and paying dentists on a fee-for-service basis; or (3) carving out the dental services and paying specialized dental managed care plans to provide Medicaid dental benefits, giving the managed care dental plan flexibility in managing the program in exchange for a capitated payment to cover dental services. According to the American Dental Association, 18 states and the District of Columbia used one or more managed care dental plans to provide Medicaid dental benefits in 2004.

Much of the Medicaid population is covered by some form of managed care, and consequently Medicaid managed care plans often provide EPSDT services. In 1991, 2.7 million beneficiaries were enrolled in some form of Medicaid managed care. According to CMS statistics, this number grew to 27 million in 2004—a tenfold increase—after the Balanced Budget Act of 1997 (BBA) gave states new authority to require certain Medicaid beneficiaries to enroll in managed care plans.[13] CMS estimates that in 2004,

[12]Throughout our testimony, the term managed care refers to capitated managed care arrangements and fee-for-service arrangements that include primary care case management arrangements. In our earlier work on states' approaches to monitoring children's access to care, we included primary care case management arrangements as fee-for-service arrangements because participating providers were predominately paid on a fee-for-service basis.

[13]The BBA allowed states to implement mandatory managed care through amendments to their state plans, as opposed to obtaining CMS approval to waive certain federal statutory provisions. The BBA also required the establishment of consumer protections in such areas as access to and quality of care for Medicaid managed care enrollees. See BBA, Pub. L. No. 105-33, §§ 4701, 4704-4705, 111 Stat. 251, 489-501(1997) (codified, as amended, at 42 U.S.C. §1396u-2).

about 60 percent of Medicaid enrollees received benefits through some form of managed care.[14]

CMS Requires States to Report Annually on Provision of EPSDT Dental Services through the CMS 416

CMS requires states to report annually on the provision of EPSDT dental services through the CMS 416, the agency's primary tool for overseeing the provision of dental services to children in state Medicaid programs. The CMS 416 is used to report a range of EPSDT services. CMS implemented the CMS 416 to comply with the Omnibus Budget Reconciliation Act of 1989 (OBRA), which required that the Secretary of Health and Human Services establish state-specific annual goals for children's participation in EPSDT services. OBRA and implementing regulations mandated state-established periodicity schedules for health, dental, vision, and hearing screenings and related services.[15] CMS initially required states to provide only one type of dental-related data: the dental assessments provided. This requirement was expanded in 1999 to collect more detailed data.

According to CMS, the CMS 416 is used to assess the effectiveness of state EPSDT programs in terms of the number of children who are provided child health screening services, referrals for corrective treatment, and dental services. Child health screening information is used to calculate the provision of health screenings and states' progress in meeting an 80 percent screening participation goal. For dental services, the CMS 416 captures, by age group, the total number of eligible children

- receiving any dental services,

[14]All states except Alaska, New Hampshire, and Wyoming have all or a portion of their Medicaid population enrolled in managed care. CMS's statistics include the Medicaid population enrolled in capitated plans and primary care case management models. These latter programs were not included as part of our 2001 and 2003 reviews related to managed care. In 2001, we reported that compared to primary care case management enrollment, about five times as many beneficiaries were enrolled in capitated managed care plans. CMS's statistics do not define the extent that Medicaid beneficiaries are enrolled in managed care that specifically cover dental services.

[15]OBRA also required blood-lead assessments (for lead poisoning) appropriate for age and risk factors. OBRA also imposed new EPSDT reporting requirements, specifically requiring states to report annually to the Secretary of Health and Human Services, by age group and by basis of eligibility, (1) the number of children provided child health screening services, (2) the number of children referred for corrective treatment, (3) the number of children receiving dental services, and (4) the state's results in attaining defined participation goals. OBRA, Pub. L. No. 101-239, § 6403, 103 Stat. at 2263 (1989) (codified, as amended, at 42 U.S.C. §1396d(r)).

- receiving any preventive dental services (each child is counted only once even if more than one preventive service is provided), and
- receiving dental treatment services (each child is counted only once even if more than one treatment service is provided).

CMS officials told us in April 2007 that CMS had not established a participation goal or other standard that states are expected to meet specifically for the provision of dental services. CMS officials told us they calculate state and national ratios only for child health screenings and participation.

The CMS 416 also requires states to report the number of individuals eligible for EPSDT services who are enrolled in managed care at any time during the reporting year.[16] States are required to report information on all EPSDT dental services provided to children, regardless of whether those services are provided under a fee-for-service or managed care arrangement.

Quality of CMS Data on EPSDT Dental Services Has Improved, but Data Have Limited Usefulness for Oversight

We have issued a number of reports that highlighted various problems in the delivery of EPSDT dental services and with the reporting of dental and other required EPSDT services provided.[17] Problems we found in 2001 with the CMS 416 reporting included states not submitting CMS 416s on time or at all and states submitting reports that were not complete because of challenges they faced collecting accurate data. In our 2001 report, we recommended that CMS work with states to improve EPSDT reporting and the provision of EPSDT services. According to agency officials, CMS has taken steps to improve the CMS 416 data.[18] However, state and national health association officials continue to cite concerns about the data's completeness and sufficiency for purposes of overseeing the provision of dental and other required EPSDT services.

[16]The CMS 416 instructions for managed care include reporting any capitated arrangements, such as health maintenance organizations or individuals assigned to a primary care provider or primary care case manager, regardless of whether reimbursement is on a fee-for-service or capitated basis (many primary care case management arrangements are paid on a fee-for-service basis).

[17]See related GAO products listed at the end of this report.

[18]Our recommendation was made to the Administrator of CMS. In the same 2001 report, we recommended that CMS develop mechanisms to share successful state, plan, and provider practices with states for reaching children in Medicaid.

State CMS 416s Are Not Always Submitted or Complete

Some states have submitted their CMS 416s late, and others have not submitted the CMS 416s at all. Further, states that did submit reports may have provided incomplete data because of challenges in collecting the data. Therefore, the reports cannot be used to provide national estimates of the provision of dental and other required EPSDT services to children in Medicaid or to assess every state's progress in providing services. We first reported this problem in July 2001. States were required to submit their fiscal year 1999 CMS 416 reports by April 1, 2000. But as of January 2001, 15 states had not submitted their reports, and another 15 states' reports had been returned by CMS because they were deficient. As of April 2007, 7 states had not submitted their CMS 416s for fiscal year 2005 (due to CMS by April 1, 2006), and another 2 states had submitted reports, but CMS considered them deficient and was working with the states to improve their reports. We estimate that these 9 states account for 20 percent of all children enrolled in Medicaid nationwide.

Another long-standing concern with the CMS 416s submitted by states has been the completeness of the data on dental and other required EPSDT services used to compile the reports. Our July 2001 report found that states faced challenges collecting data on EPSDT services from both fee-for-service providers and managed care plans. Under the fee-for-service approach, providers bill the state for each EPSDT service they deliver. Thus, data on EPSDT services are often collected by the state as part of the payment process. Most of the states we examined for our 2001 report had some difficulty obtaining complete and accurate data from fee-for-service providers—for example, due to coding or system issues. States faced more extensive problems obtaining data from capitated managed care plans. Unlike fee-for-service arrangements, when capitated managed care plans pay their participating providers a flat fee per beneficiary regardless of services provided, the providers do not need to submit information on each service provided in order to receive payment. Thus plans have had difficulty reporting on the provision of specific EPSDT services separately as required by states.

CMS Has Taken Steps to Improve Quality of the Data, but Concerns Remain

CMS officials have reported taking several actions in response to our 2001 recommendation that the Administrator of CMS improve EPSDT reporting.[19] CMS reported, for example, that it had started assessing states' CMS 416s as part of periodic focused reviews conducted by CMS regional offices. We reported in 2001 that CMS regional office reviews of states' EPSDT programs had been helpful in highlighting policy and process concerns, as well as innovative state practices. Since 2002, according to CMS in April 2007, the agency had conducted focused reviews in 11 states. These reviews have evaluated, among other things, state data collection and reporting, including the extent to which the state develops its CMS 416 in accordance with instructions and uses the data to measure progress and define areas for improvement. During these reviews, CMS found deficiencies, such as incorrect coding and incomplete data. CMS made specific recommendations to the states that would improve the reliability of the state-generated CMS 416 data.

Another step CMS has taken that has improved the quality and completeness of the data states can use to compile their 416s was to require states to gather encounter data from Medicaid managed care plans. The BBA and implementing regulations require states that contract with managed care plans to implement a quality assessment and improvement strategy that included procedures for monitoring and evaluating the quality and appropriateness of services provided under the contracts. States are also required to ensure that managed care plans maintain a health information system and report encounter data.[20] CMS also developed a protocol for states' use for validating encounter data. Officials from several states and national health associations we contacted in preparation for this hearing generally said that, although problems remain, the quality and completeness of the underlying data, such as managed care encounter data, that states used to prepare the CMS 416, had improved since 2001. CMS officials indicated a number of efforts were underway to

[19]See footnote 23.

[20]The BBA required states that contract with managed care plans to implement a quality assessment and improvement strategy that includes procedures for monitoring and evaluating the quality and appropriateness of services provided under the contracts. Pub. L. No. 105-33, §4705, 111 Stat. 498-501 (1997) (codified, as amended, at 42 U.S.C. §1396u-2). Implementing regulations published in 2002 required, for example, that states ensure that managed care plans maintain a health information system that collects, analyzes, integrates, and reports data. This health information system must collect data on enrollee and provider characteristics as specified by the state and on services furnished to enrollees through an encounter data system or other methods as may be specified by the state. See 42 C.F.R. § 438.242.

evaluate other quality and outcome measures of dental services provided to children enrolled in Medicaid. For example, one measure CMS is considering is the Quality Compass developed by the National Committee for Quality Assurance that provides plan-specific, comparative, and descriptive information for use as a health plan benchmarking tool.

But despite these improvements, officials from states and from national health associations remain concerned that the CMS 416s are unreliable for developing national estimates of the provision of dental and other required EPSDT services and therefore insufficient for oversight purposes. Although some officials cited some uses of the CMS 416, for example, as a set of basic indicators of the extent to which children use dental services over time, the officials cited several different problems.

- **Inconsistent data collection.** Citing differences in how states collected data on dental EPSDT services, an April 2005 National Oral Health Policy Center report stated that comparing the number of children receiving services over time or examining the rate of dental utilization across states should be done with caution. The Center's director provided several examples. For instance, some states inappropriately reported oral health assessments conducted in group settings, such as those performed by nurses or other non-dentist health providers in schools, as dental examinations. Likewise, some states inappropriately reported oral health assessments provided by hygienists as dental examinations. According to the director, such assessments should not be considered dental examinations.

- **Coding inconsistencies and anomalies.** CMS 416s may not accurately reflect the provision of dental and other required EPSDT services, according to an official from the National Academy for State Health Policy speaking about research she had done in 2002 and 2004. States have reported that discrepancies exist between managed care plans and state Medicaid agencies in the definitions of ESPDT services. Similarly, we reported in 2001 that states faced such issues in collecting CMS 416 data for the range of EPSDT services that might be provided during a comprehensive office visit. For example, providers in Florida were required to use a specific EPSDT code and a claim form to document the components of EPSDT services they provided. However, according to state officials, providers often chose to use other codes instead. According to the officials, some providers submitted claims under a comprehensive office-visit code for a new patient that paid a higher rate than an EPSDT screening, or used other comprehensive office-visit codes that required less documentation. Specific to dental EPSDT services, the George Washington University Medical Center reported in December 2003 that

several Medicaid program representatives said that it was difficult to separate specific provided services in EPSDT data reported by managed care plans to determine the provision of dental screening services because providers did not always bill for those services separately.[21]

- **Changes in beneficiary eligibility**. Gaps in children's eligibility for Medicaid and movement of children between Medicaid and other health insurance plans may also cause problems in accurately determining the extent that Medicaid children received dental and other required EPSDT services. One official told us that interrupted Medicaid eligibility, accompanied by the implementation of the State Children's Health Insurance Program,[22] has also caused problems in the data on the number of children eligible for services. As children move between health insurance programs as their program eligibility changes, officials reported that it becomes difficult to maintain an accurate count of Medicaid-eligible children. Without an accurate count, an accurate rate of the provision of the dental and other required EPSDT services to eligible children cannot be calculated.

CMS 416s Have Limitations for Oversight Purposes

The type of data collected on the CMS 416 has limited usefulness for purposes of oversight, as officials from states and national health associations have noted. Many officials from national health associations told us that the CMS 416 did not provide enough information to allow CMS to assess the effectiveness of states' EPSDT programs. One official who works with many state Medicaid agencies told us that states do not generally use the CMS 416 to inform their monitoring and quality improvement activities, but instead rely on other sources of data. Some state officials reported using the CMS 416 data, but noted that they supplement the data with additional information.

[21]See *Accountability in Medicaid Managed Care: Implications for Pediatric Health Care Quality*, the George Washington University Medical Center School of Public Health and Health Services, December 2003. Funded by the David and Lucile Packard Foundation.

[22]The State Children's Health Insurance Program (SCHIP) is a federal and state program that finances health insurance for children and certain adults whose incomes are low, but are above Medicaid's eligibility requirements. States may implement SCHIP programs by expanding Medicaid programs, developing separate SCHIP programs, or a combination of both. If a state elects Medicaid expansion, it must provide EPSDT services to SCHIP beneficiaries.

The limitations noted generally fell into three categories. First, while states report the total number of children enrolled in managed care plans, dental and other required EPSDT services delivered to managed care enrollees are not reported separately from fee-for-service enrollees. Consequently, the data captured by the CMS 416 cannot be used to specifically monitor the provision of dental and other required EPSDT services under either fee-for-service or managed care arrangements.

Second, the information captured by the CMS 416 is limited to summary statistics, such as age group, eligibility, state requirements, and services delivered, and does not provide information that would illuminate whether children have received the recommended number of visits for dental and other required EPSDT services. For example, a concern raised by a national health association official was that the CMS 416 did not provide information about whether eligible children had received the number of biannual preventive dental visits that are required by the state or recommended by the American Academy of Pediatric Dentistry. Because each child is counted only once each fiscal year, regardless of the number of dental services or preventive dental services the child received that year, the data do not reflect the total number of dental appointments each child had in any given year.

Third, CMS 416s do not contain information that would illuminate any of a number of factors that may contribute to low use of dental and other required EPSDT services among children enrolled in Medicaid. Our 2001 report found that children's low utilization of EPSDT dental and other services could have been attributed to program-related matters, such as limited provider participation in Medicaid or inadequate methods for informing beneficiaries of available services. In addition, some beneficiary-related factors, such as changing eligibility status or language barriers, could have limited utilization of services. Also, our 2000 report on factors contributing to low utilization of dental services by Medicaid and other low-income populations found that the primary contributing factor among low-income persons with coverage for dental services was difficulty finding dentists to treat them. Dentists generally cited low payment rates, burdensome administrative requirements, and such patient issues as frequently missed appointments as the reasons why they did not treat more Medicaid patients.[23] Additional, more specific information

[23]GAO/HEHS-00-149.

would be needed to supplement the information collected in the CMS 416 to further understand these factors.

Concluding Observations

Millions of low-income children enrolled in Medicaid should have access to important services to treat dental disease, as intended by Congress in mandating the coverage of and reporting on the provision of EPSDT dental services. Services to identify and treat tooth decay—a chronic problem among low-income populations and a preventable disease—are critical for ensuring that the nation's children and adolescents are healthy and prepared to learn. Unfortunately, as we reported in 2001 and 2003, data for gauging Medicaid's success in providing these important services to enrolled children are unreliable and incomplete. CMS and states have taken a number of steps to improve the data, but problems persist. Moreover, concerns have been raised that the reported data on EPSDT dental services have limited utility for determining how to improve children's access to these services. Strengthening the safety net for children in Medicaid will require additional efforts to gather more complete and reliable information on the delivery of dental and other ESPDT services.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other members of the Subcommittee may have at this time.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please contact James C. Cosgrove at (202) 512-7118 or at cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Katherine Iritani, Assistant Director; Emily Beller; Terry Saiki; and Timothy Walker made key contributions to this statement.

Appendix I: CMS Form 416

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

State_____FY_____		Age Groups							
		Total	<1	1-2*	3-5	6-9	10-14	15-18	19-20
1. Total individuals Eligible for EPSDT	CN								
	MN								
	Total								
2a. State Periodicity Schedule									
2b. Number of Tests in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule									
3a. Total Months of Eligibility	CN								
	MN								
	Total								
3b. Average Period of Eligibility	CN								
	MN								
	Total								
4. Expected Number of Screenings per Eligible	CN								
	MN								
	Total								
5. Expected Number of Screenings	CN								
	MN								
	Total								
6. Total Screens Received	CN								
	MN								
	Total								
7. Screening Ratio	CN								
	MN								
	Total								

* Includes 12 months + or -
Note: "CN" = Categorically Needy; "MN" = Medically Needy

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State_____ FY _____		Age Groups							
		Total	<1	1-2*	3-5	6-9	10-14	15-18	19-20
9. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CW								
	MW								
	Total								
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	CW								
	MW								
	Total								
10. Participant Rate	CW								
	MW								
	Total								
11. Total Eligibles Referred for Corrective Treatment	CW								
	MW								
	Total								
12a. Total Eligibles Receiving Any Dental Services	CW								
	MW								
	Total								
12b. Total Eligibles Receiving Preventive Dental Services	CW								
	MW								
	Total								
12c. Total Eligibles Receiving Dental Treatment Services	CW								
	MW								
	Total								
13. Total Eligibles Enrolled in Managed Care	CW								
	MW								
	Total								
14. Total number of Screening Blood Lead Tests	CW								
	MW								
	Total								

* Indicates 12-month old

Note: "CW" = Categorically Needy, "MW" = Medically Needy

Related GAO Products

Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care. GAO-03-222. Washington, D.C.: January 14, 2003.

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. GAO-01-749. Washington, D.C.: July 13, 2001.

Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations. GAO/HEHS-00-149. Washington, D.C.: September 11, 2000.

Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations. GAO/HEHS-00-72. Washington, D.C.: April 12, 2000.

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Mr. KUCINICH. I thank the gentleman.

We will now hear from Mr. Smith.

STATEMENT OF DENNIS SMITH

Mr. SMITH. Good afternoon, Mr. Chairman and members of the committee. It is a pleasure to be with you this afternoon.

I hope that I am helpful to you in helping you to sort out the Medicaid system, itself, how it works, that it is a partnership with our States. The Federal Government funds approximately 57 percent of the Medicaid program. The States fund 43 percent of the Medicaid program on a national basis. That varies by State, which is calculated every year by what is called the FMAP, the Federal Matching Assistance Percentage. That changes every year.

While there is a Federal framework for Medicaid program, itself, States have flexibility within that framework. Above the Federal mandated eligibility groups, for example, the States can go higher up in the eligibility groups. There are certain mandatory services spelled out in the Federal Medicaid program. There are certain optional services that are provided for under Federal law.

States control the reimbursement rates. It is the States who set how much they will pay their providers. In terms of dental, in particular, and services for children, all children are eligible for, as has been mentioned earlier today, EPSDT, and therefore for all dental preventative benefits and treatment that they may need. In fact, Medicaid in many respects is a richer benefit package than what you would find in your typical private insurance benefit package, as it does cover all those preventative care, as well as treatment.

In terms of Medicaid being a system, again the Federal law provides for certain rights and appeals that the beneficiary has. Those appeals are generally heard at the State level, that they are appealed at that State level.

The managed care organizations that again have been referenced earlier this afternoon, it is the States that contract with those health plans. There are certain enforcement provisions that are available to the States for health plans that do not live up to their contractual obligations and to the requirements of the Medicaid program, so there is an enforcement on the State side, as well.

On the Federal side, we did hear a little bit earlier today about sanction and enforcement. Sanction and enforcement at the Federal level against the States fundamentally means taking money away from the States. That is the sanction that the Federal Government has. And I think that is a responsibility that we do not take lightly. It is a responsibility that is important to bear in mind that, in fact, is what we are talking about. When the Federal Government is enforcing compliance, that is a financial penalty against the States.

In terms of dental, we have heard this morning—I think Dr. Clark gave my testimony for me in terms of pinpointing the real pressure points on the Medicaid system: low reimbursement rates, patient education and awareness, and compliance as being the issues, but he also fundamentally also said in his testimony the real issue is about funding. Funding is determined by the State, not by the State Medicaid Director but by those men and women who get elected to make those decisions in the State capitals. They

are the ones who set the reimbursement rates. They are the ones who make those difficult decisions of balancing priorities. Where do we put our dollars? Do we put them into expanding eligibility? Do we put them into provider rates? Do we put them into more services?

The competing interests and the competing values that are worked out at the State level really are fundamental to everything else that you see. It all really reflects those decisions that get made.

The EPSDT form 416, I think everyone acknowledges we have struggled with the accuracy of what 416 tells you. Fundamentally, it does tell you the percentages of children who had any dental treatment whatsoever. It tells you whether they had preventative treatment, as well, and it tells you the percentage of the children who are in managed care organizations.

We all acknowledge, I think on everybody's part, I think, the difficulty of moving from EPSDT reporting on 416, which really in effect reflected a fee for service environment, to where now we have moved to the managed care environment. How do we sort that back out?

But I would suggest that form 416 is not the only thing that has informed us that there are issues in terms of access for Medicaid recipients. In 1998, the State of Maryland knew it had a problem with access. It had a Statewide effort to identify those issues. In 2000, the GAO told Congress that there is a problem with access in the Medicaid program. States do go out. They do their own. There are a number of reports and studies you can get, like researchers from the gentlemen on the previous panel that are going out there and telling you, telling all of us that there is an access problem for Medicaid recipients for dental care. They are also telling us why.

Mr. Chairman, I look forward to your questions.

[The prepared statement of Mr. Smith follows:]

Testimony of Dennis G. Smith
Director, Center for Medicaid & State Operations
Centers for Medicare & Medicaid Services
on
"Oversight of State Performance & Access to Dental Care for Medicaid Beneficiary Children"
Before the
House Oversight & Government Reform
Subcommittee on Domestic Policy
May 2, 2007

Good afternoon Chairman Kucinich, Representative Issa, and distinguished members of the Subcommittee. I am pleased to be here today to discuss oversight of state performance and access to dental care for children who are served by the Medicaid program. Medicaid is a shared partnership between the Federal Government and the States that will provide more than $300 billion in benefits this year. The Federal Government provides financial matching payments to the States while each State designs and runs its own program within the Federal structure and is responsible for administering its Medicaid program.

The Centers for Medicare & Medicaid Services (CMS) works with State Medicaid agencies to encourage quality care, adequate access, and appropriate use of Federal Medicaid resources.

Dental Coverage for Low-Income Children

Oral health care benefits are available for all 29 million children on Medicaid. States must provide dental screenings and diagnostic, preventive, and treatment services to children in order to receive federal matching funds. Preventive services may include oral exams, fluoride treatment, and sealants. Treatment services may include any medically necessary services including filling caries and performing extractions.

States also offer dental coverage through their State Children's Health Insurance Program (SCHIP) for nearly 6.6 million children. Currently, forty-nine (49) States and the District of

Columbia offer dental coverage through SCHIP. Many States provide coverage identical to that offered through Medicaid while others customize their benefits.

Services may be delivered on a fee-for-service basis or through Managed Care Organizations (MCOs). Nationally, 29.5 million individuals on Medicaid or 65 percent are served through MCOs.

Beneficiary Assistance and Protections

States typically help Medicaid populations to access services in a variety of ways ranging from providing general information on the eligibility determination process to the grievances and appeals process available to all Medicaid beneficiaries. All States have toll-free hotlines to assist individuals in identifying available providers in their communities. Many children, especially those with special needs, have case workers assigned to connect them with medical and social services they may need. Multiple contact points exist through providers, out-stationed eligibility workers, Federally Qualified Health Centers and other local community health clinics, schools, social service agencies, the foster care system, child protective services, and the State and local mental health systems.

All Medicaid applicants and recipients have the right under Section 1902(a)(3) of the Social Security Act and CMS regulations (at 42 CFR 431.200-250) to request a fair hearing when the State makes an adverse decision such as denial or termination of eligibility or denial of a service either because the service is not covered under the plan or because the service does not meet the criteria for coverage established by the State. An individual who exercises his appeal rights will receive, at a minimum, a fair hearing by an officer designated by the State.

Every State must give the individual a reasonable amount of time, not more than 90 days, to request an appeal. To ensure timely actions, the State has 90 days from the date an appeal is requested to render a decision. A recipient can continue to receive the contested services while appealing but generally file the appeal within 10 days from the date the notice is sent by the State. The notice at each stage of the appeal process informs the recipient of the decision, the

reasoning used and any further appeal rights, including the extent to which the individual may appeal to the State courts.

CMS also developed several regulations to protect consumers receiving care through a managed care delivery system when it became evident that managed care held promise for cost, efficiency and quality in Medicaid. Under these arrangements, consumers also have a right to an appeal if services are denied, limited, or not provided in a timely manner. They also have the right to file grievances about any matter such as concerns about quality of care, provider behavior, or failure to respect the enrollee's rights. Medicaid law and regulations provide for a variety of sanctions against an MCO for failure to meet requirements.

States are required to ensure that MCOs are following Medicaid requirements. CMS provides oversight and monitoring of these activities by reviewing External Quality Review reports which are required for every State that has a managed care delivery system. CMS has developed tools and conducted conferences to help States with their External Quality Review functions. CMS also has regularly scheduled calls with state Technical Advisory Groups made up of State Medicaid Managed Care and Quality Improvement Directors to implement the recommendations.

States have engaged in many activities to provide access to quality dental services for children. For example:

- Alabama established a Governor's Dental Task Force for improvement, raised dental fees and provided case management services to assist patients in keeping appointments.
- Michigan contracted with a commercial company for the provision and administration of dental benefits in certain rural counties. This provided Medicaid beneficiaries with benefits similar to commercial coverage.
- Virginia contracted with a single dental insurance company to administer its programs for both Medicaid and SCHIP. This change provided many administrative benefits, streamlined the process and increased the number of dentists available to provide services.

Maryland Efforts

Over 370,000 children in Maryland receive care through a comprehensive managed care delivery system. In 2004 the State passed legislation requiring dentists who participate in their managed care plan to notify the MCOs when enrolled children are in need of dental therapeutic/restorative treatment that the dentist was unable to provide. Maryland also imposed incentive / disincentive payment arrangements on MCOs based on their provision of dental services to children ages 4 – 20.

Also, MCOs are required to provide families with a list of participating dentists who provide the needed therapeutic/restorative treatment, and assist the family, if necessary, in arranging an appointment for the needed care if necessary. An MCO's compliance with the requirements is monitored on an ongoing basis by the State.

Maryland also has a consumer hot line that records complaints from MCO members and is used to monitor services and intervene as necessary. A provider hotline is also in place that records complaints regarding Medicaid operations including reimbursement rates.

The State, through its managed care providers, implements outreach and consumer protection activities including:

- Automated calls, letters, and postcards to members reminding them to seek healthcare services at appropriate time intervals.
- Follow-up with beneficiaries that have not followed through on appointments by coordinating with the county health departments for outreach.
- A dental outreach effort, entitled "Healthy Smiles", in which incentives are provided to members who seek primary dental care.

In 1998 Maryland assembled an Oral Health Advisory Committee, which has developed an Oral Health Action Plan. Maryland also increased their provider rates for physicians, including dentists, by nearly $200 million after receiving waiver approval from CMS. In addition, the Maryland General Assembly passed a legislative initiative that appropriated $1 million per year of additional funding for the Medicaid dental program, beginning in 2009. The State reports that

after implementation there was a corresponding increase in the number of providers and in recipients being served.

Also, the Maryland legislature has instituted a loan repayment program for dental students, which requires, among other things, that they provide services to Medicaid patients. Through this loan repayment program, Maryland expects to add 15 new dentists per year to the rolls of Medicaid providers. Maryland also has 78 health care delivery sites operated by Federally-funded community health centers.

As a result of the innovative approaches taken by Maryland, the State has realized improvement in quality and access as demonstrated by increases in their Health Plan Employer Data and Information Set (HEDIS) performance measures, which are used to measure quality. Between 2001 and 2004, the State of Maryland used HEDIS to measure children's access to primary care physicians, adult access to preventive and ambulatory health services, well-child visits, prenatal and postpartum care, comprehensive diabetes care, and use of appropriate medications for asthma. In all categories, except the use of appropriate medications for asthma, Maryland exceeded the Medicaid average. In fact from 2001-2004, Maryland rates consistently trended upwards, at a rate of change between 3 percent and 11 percent.

In the case of dental services, 2005 data indicate that 33 percent of children received dental services, in contrast to 19 percent in 1998. This rate is the same as the national average for Medicaid dental visits according to 2005 CMS data.

Other Sources of Dental Coverage:

Medicaid is just one source of dental coverage for low-income families and children. Many low-income children and their families can receive dental services through public health programs, community health centers, or dental schools that provide free or reduced-fee services. The Centers for Disease Control and Prevention leads federal efforts in promoting oral health through public health interventions and has helped states strengthen their oral health programs, has reached people hardest hit by oral diseases, and has expanded the use of measures proven effective in preventing oral diseases. In addition, the Health Resources and Services Administration (HRSA) has an Oral Health Disparities Collaborative which is working to

provide greater access to oral care for children, and the Indian Health Service provides dental care to eligible American Indians and Alaska Natives.

HRSA's Maternal and Child Health Bureau partners with agencies for families and children and the Head Start Program to provide greater access to dental care for children enrolled in Head Start. HRSA also funds pediatric dental training residencies. For pediatric doctor residents, HRSA offers an "all health" curriculum that integrates oral health into overall health care.

Community Health Centers including, Federally Qualified Health Centers, including HRSA's funded health centers, play a critical role in providing dental services and transportation. These centers provide services regardless of an individual's ability to pay, even if the patient has no health insurance. The percentage of health centers providing preventive dental services onsite has increased steadily since the beginning of the President's initiative in 2001. At the end of calendar year 2005, there were over 950 federally-funded health centers with more than 3,745 primary care delivery sites located in urban and rural underserved areas. Overall, 84 percent of health centers provide preventive dental services, an increase of over 30 percent since 2001. In addition, the number of health center dental staff has increased by 70 percent over the 2001 total.

Challenges

In an April 2000 Urban Institute study, *Gaps in Prevention and Treatment: Dental Care for Low-Income Children*, researchers identified "[t]hree factors that may impede utilization of dental services by children: lack of knowledge about or low priority given to meeting recommended dental care standards, lack of access to providers, and a lack of means to pay for care." This report was based on the 1997 National Survey of America's Families and included information about children with private health insurance, public health insurance, as well as those who were uninsured.

Interestingly, the use of dental care between privately and publicly insured children was quite similar but the barriers they faced differed. The study found that 17 percent of uninsured children had unmet need, but only 7 percent of publicly insured children and 5.7 percent of privately insured children had an unmet need. The percentage of children with no dental care

visits for publicly insured children and privately insured children was 23.8 percent and 23 percent respectively, compared to 35 percent for uninsured children.

Medicaid benefits for dental care for children are more comprehensive than benefits typically offered to children who are privately insured. Underinsurance and variations in coverage are likely the primary barriers for privately insured children, while the primary barrier for children with Medicaid coverage is likely to be access to care.

Historically, low dental provider participation has been a challenge in a number of State Medicaid programs. Low provider enrollment is generally attributed to low Medicaid reimbursement rates in the States; beneficiary non-compliance/missed appointments; and an overall lack of available dentists in certain rural or urban areas.

In one study conducted for the Minnesota Department of Human Services between November 2000 and February 2001, *Perspectives of Dentists and Enrollees on Dental Care Under Minnesota Health Care Programs*, the State surveyed both providers and enrollees to gain better insight into the oral health care challenges faced in public programs. From the provider perspective, low fees and broken appointments were the most commonly identified problems in serving individuals enrolled in the Minnesota Health Care programs, which includes Medicaid and other State programs. Overall, 93 percent of dentists reported that low reimbursement fees were a very significant problem. Less than 1 percent of dentists reported they were receiving fees that they considered acceptable. The second most common reason for low provider participation was broken or cancelled appointments, with 82 percent of dentists reporting this as a significant problem.

There are also important lessons to be learned from the enrollee perspective. According to the report, the survey of more than 12,000 enrollees showed that only 50 percent of parents/guardians (reporting on behalf of a child) did not accept the need for preventive dental care. However, for those expressing a need for dental care, 88 percent of children were able to receive it. Enrollees reported that about one-third experienced difficulty finding a dentist, of

which 17 percent described the problem as "big" and 14 percent described as "small." Access problems for children differed by region.

In light of these challenges, CMS continues to work with key partners to ensure that patients have access to dental care. Improvements to access, quality and reporting will continue as states implement evidence-based performance measurement supported by health information technology (HIT).

CMS Oversight and Access to State Dental Benefits

When considering efforts to ensure children's access to dental health in the Medicaid program, again it is critical to remember that Medicaid is a joint Federal-State effort, with States having the primary responsibility for administration of their programs within Federal guidelines. The Medicaid program has a number of checks and balances that facilitate identification and resolution of problems in addition to those previously mentioned for beneficiary protection. The States have the responsibility to work directly with their providers and beneficiaries, and CMS monitors States to ensure that they are in compliance with their plans and Federal law.

CMS works with States to prevent and correct systemic issues as they become known through internal and external review processes. For example, CMS worked to implement recommendations from the 2001 Government Accountability Office Review on Children's Access to Health Screening Services which centered around Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) reporting and providing a mechanism for sharing information among States on successful State plans and provider practices for reaching children in Medicaid. Through our work with States, the participation ratio in all EPSDT services increased by 32 percent since 1999 and the percentage of children receiving dental services increased by 23 percentduring the same time period. In Fiscal Year 2008 it is estimated that Medicaid will spend in excess of $700 million on EPSDT screenings.

In addition to oversight, CMS also works to improve access by aligning payment structures. For example, to further address the challenges to enrolling providers in Medicaid due to fee and reimbursement issues, CMS approves State Plan Amendments (SPAs) that call for payment for

dental services at the level of charges, as long as the charges are applied equally to all payers. Section 1902(a) (30) (A) of the Social Security Act requires that Medicaid payments be consistent with efficiency, economy and quality of care. Normally, CMS does not recognize payment up to charges as being economic and efficient because charges are set by the provider. However, in the case of dental access, payment up to charges is an important tool available to State Medicaid agencies to encourage the availability of quality dental services. CMS also permits States to pay up to the Average Commercial Rate (ACR) for dentists.

CMS' Medicaid Quality Initiatives

The CMS quality initiatives include moving States towards quality assessment of Medicaid and SCHIP services through evidenced-based performance measurement and dissemination of best practices.

CMS is currently exploring many options to improve data collection and monitoring to inform quality decisions. One important source of data that already exists is the annual EPSDT report, CMS Form-416, which provides basic information on states' compliance with EPSDT requirements. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receive dental services. States must submit a Form 416 annually. CMS works with States on an ongoing basis to improve the quality of the data provided on the Form 416 to better assess the types of services provided (e.g., the percentage of Medicaid-eligible beneficiaries receiving preventive dental and treatment services).

States have historically had problems capturing managed care data with Form 416. CMS has recently purchased the National Committee for Quality Assurance (NCQA) Quality Compass to determine if it might be a better source of data for Medicaid MCOs. While the Quality Compass is a very reliable and valuable source of audited data, not all health plans report to the database. It cannot currently be used for national analyses.

Like many traditional reporting mechanisms, CMS believes that Form 416 has limitations in an era of electronic health records and quality improvement supported by health information

technology. As a result, CMS has launched a "Value-Driven Health Care" initiative in support of the Secretary of HHS' priorities to ensure interoperable health information technology, transparency in quality information, transparency in price information, and value-based purchasing. States are requested to move rapidly into using national performance measures and interoperable systems that will help improve reporting in all areas including EPSDT. CMS and its sister agency, the Agency for Healthcare Research and Quality (AHRQ), will provide support to states in these efforts.

To increase education of preventive services available through Medicaid, CMS partnered with the American Academy of Pediatric Dentistry (AAPD) in 2004 to produce a *Guide to Dental Care* for Medicaid. Information provided through its publications, websites and community partnerships, has helped children get the preventive and dental care they need.

CMS has reached out to low-income parents to inform them of the importance of screening and health maintenance through a series of brochures entitled "Healthy Start, Grow Smart." The brochures cover a number of areas related to health, growth and development including dental education to prevent tooth decay and the need to visit a dentist. We believe that education about early use of dental care is important to participation and compliance. CMS has distributed over 51 million Healthy Start brochures to low-income children and families nationwide.

We certainly need our external partners as well. For example, the ADA has an online guide to *State Innovations to Improve Dental Access for Low-Income Children: A Compendium.* This compendium identifies and summarizes successful state interventions related to Medicaid/SCHIP oral health care for children.

More recently, CMS began the process of integrating EPSDT services into an overall CMS Medicaid Quality Strategy to move toward a more contemporary and comprehensive approach to achieve the goal of delivering the right care, for everyone, every time.

- Under this initiative, CMS continues a dialogue with the American Dental Association that began in late 2006. Discussions include exploring the development of quality measures related to value-based purchasing in dentistry.

- CMS and AHRQ meet regularly with State Medicaid Medical Directors to discuss promising practices and devoted an entire session to EPSDT services last spring.
- CMS established a Medicaid/SCHIP Quality page on its Web site to share promising practices in all areas of Medicaid. Targeted topics related to EPSDT include access, asthma, dental, diabetes, health disparities, health information technology and performance measurement. CMS is in the process of populating this page, which can be found at can be found at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/;
- In late 2006 CMS published The Guide to Quality Measures: A Compendium, which contains nationally recognized, tested, and vetted quality measures to support States' programmatic needs in many areas of quality improvement. The site can be found at www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/pmfinalaugust06.pdf.

CMS Regional Offices (ROs) are involved in numerous activities with States regarding EPSDT and oral health issues. A few examples of RO activity include:

- Monitoring submittal of CMS Form- 416 reports and performing EPSDT oversight reviews by interviewing State staff, providers and community partners;
- Reviewing and providing input on State plan amendments and waiver applications for programs impacting children and pregnant women;
- Developing a curriculum for, and providing a one-day EPSDT 101 training for States, and;
- Providing technical assistance to regional Head Start programs.

Conclusion

CMS has made significant progress in overseeing and promoting quality pediatric dental benefits in the Medicaid program. We know our work is not over and we must remain vigilant and proactive. Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.

Mr. KUCINICH. Thank you very much, Mr. Smith.

Mr. CUMMINGS. Would the chairman yield?

Mr. KUCINICH. Yes, Mr. Cummings.

Mr. CUMMINGS. Mr. Chairman, I just would like to ask Mr. Smith a few questions.

You mention in your prepared statement that your agency partnered with experts to produce a guide to dental care, and that this publication and community partnerships has helped get children the preventive and dental care that they need; did you not? Did you say that in your written statement?

Mr. SMITH. In our testimony.

Mr. CUMMINGS. Yes, you did. I would like to ask you some questions about that guide.

It is my understanding that the original draft of that guide was submitted to your agency in 2001, but that you did not publish it until 2004; is that correct?

Mr. SMITH. I believe that is correct.

Mr. CUMMINGS. That is correct. It took you 3 years to publish a 52-page document. But, more important than the delay, the original draft of the guide and the published guide are very different. Did you know that? Are you aware of that?

Mr. SMITH. Oftentimes reports and studies go through a number of layers of review. Yes.

Mr. CUMMINGS. Well, someone made a lot of changes in this instance. Let me just point some of them out to you.

For instance, the original draft contained the statement "National surveys and Federal and State studies continue to demonstrate substantial disparities in both oral health and access to services. Only a small percentage of children enrolled in Medicaid receive safe and effective preventive measures." These are the statements that were in the original statement.

These statements make it clear that most children in Medicaid are not getting good dental care. Someone took out these statements. Do you know why they did?

Mr. SMITH. Not offhand, sir. It is a statement I would agree with. We know that we have access problems in the Medicaid program.

Mr. CUMMINGS. But yet still someone from your agency took out the very statements that you now say were true. Do you understand that?

Mr. SMITH. I——

Mr. CUMMINGS. Do you know why?

Mr. SMITH. Not offhand, sir, no.

Mr. CUMMINGS. And so you do believe that most children in Medicaid are not getting good dental care; is that right?

Mr. SMITH. I think we all acknowledge that there are access problems for children in the Medicaid program.

Mr. CUMMINGS. It gets worse. The original draft contained these statements: "The Medicaid program is ultimately responsible for ensuring that the child receives a complete diagnostic evaluation, and for developing quality assurance procedures to assure comprehensive care." And it goes on. This is the original statement: "State Medicaid programs are ultimately responsible for assuring that direct referrals are made, that necessary followup and treat-

ment services are made, and that children identified as needing such services get to dentists' offices."

These statements make it clear that the Federal and State governments are ultimately responsible for assuring that children get dental care. But guess what—somebody took them out. Why? Why is that, Mr. Smith?

Mr. SMITH. Again, sir, I don't know.

Mr. CUMMINGS. You don't know.

Mr. SMITH. I'm saying I do not remember as——

Mr. CUMMINGS. But do you agree with the original statements?

Mr. SMITH. I think this statement, again, is what I have stated here this morning. We have a responsibility to make sure that children on Medicaid have access to those services, and access to those services in Medicaid has been a longstanding problem.

Mr. CUMMINGS. Do you believe that the State government is not responsible for assuring that children in Medicaid get dental care?

Mr. SMITH. I believe that the children on Medicaid have a right to dental care and it is a responsibility that individuals who are entitled to that care receive it.

Mr. CUMMINGS. By the way, a little bit earlier you talked about sanctions. Has anybody been sanctioned? Any State been sanctioned?

Mr. SMITH. I have not sanctioned States for not increasing reimbursement rates. I would have to go back to see in the 40 year history whether that has been——

Mr. CUMMINGS. Sir, you——

Mr. SMITH [continuing]. A tool that the Federal Government——

Mr. CUMMINGS. But you don't know of any sanctions; is that right? Anybody being sanctioned?

Mr. SMITH. I have been Medicaid Director since July 2001. I can assure you I have not sanctioned a State for the access issues in dental care. In dental care what we have been seeing is that States have improved their performance, and a greater percentage of children are receiving dental care than they did previously. So we do see improvement in access. Access is still a problem.

Mr. CUMMINGS. Thank you very much.

I yield back.

Mr. KUCINICH. I thank the gentleman.

We are going to go to Mr. Shays.

Mr. SHAYS. Thank you.

Mr. Smith, I remember when I was chairing the contract that oversees the Department of Health a number of years ago the then Secretary of HHS actually testified before my subcommittee, and for 2 years the Clinton administration did not move forward on a Commission that was supposed to help ensure the safety of the blood supply. I just remember we lost 25,000 hemophiliacs to AIDS because of that.

Well, it was important to me, and the reason why she testified was just trying to understand what she could do better. So I knew her heart was in the right place. I didn't want to rail on her for 2 years of inaction by the Department because I knew that she was working on so many issues.

So she came and testified and said what she is going to do, and it was very impressive, and we licked the problem, but it existed for a while.

I am less interested in where there is a failing right now in the past. I am more interested to know—and I need to know where you come down on this—how can I feel comfortable when a doctor is only getting 20 or 30 percent of what they should get, and that we have a fraction, anywhere from 10 to 16 percent, of the doctors participating, so there aren't many choices of where they can go. Why should I feel comfortable with that?

Mr. SMITH. Mr. Shays, I think that, again, I would say the decisions about what providers get paid how much money really is a decision that gets made in the State capitals.

Mr. SHAYS. OK. That is not what I asked. That is not what I asked at all.

Mr. SMITH. OK.

Mr. SHAYS. But why should I feel comfortable the State only gives anywhere from 10 to 16 percent of what a doctor—first of all, we only have one doctor basically participating, maybe two. He is overworked. He has a waiting list of 6 months. He loses money. He basically spends 2 days a week giving away money is what he does because he believes in it, and he has one practice in the more affluent part of my town, in my District, and then he has another practice in Bridgeport. He would not be able to pass that practice on in Bridgeport to anyone. No one would take it. He can't even get a young doctor coming out of dental school because they have large dental costs.

So I am going to ask it again, whether or not you think you should change it. Why should I feel comfortable with that process?

Mr. SMITH. I think the changes that you see in health care as health care continues to evolve and Medicaid does, as well——

Mr. SHAYS. You know what the answer should be? It is a simple one. If I was advising you before you were testifying before this committee, it is not your fault, you could have just come and said we shouldn't be comfortable and we need a plan to deal with that. I mean, I would think you would be advocating States fund this system better and make sure doctors get—I mean, heck, they could at least get $0.50 on the dollar. I mean, if it costs someone to pay their employee $60 for a $20 reimbursement, they are actually taking money out of their pocket and giving it away. That is the system we have here.

The answer is I shouldn't feel comfortable. The difference between you and the former Secretary of HHS is she would have come here and said we shouldn't be comfortable and we are going to lick it.

Why I am not feeling very sympathetic toward you right at the moment is that you don't think there is a problem.

Mr. SMITH. I disagree that I didn't say there is not a problem. I think I said very clearly there is a problem with access to dental services.

Mr. SHAYS. So?

Mr. SMITH. And the solutions, again, have been spelled out a number of times by GAO, by——

Mr. SHAYS. But what I recommend——

Mr. SMITH [continuing]. Many, many places about what the problem with access is.

Mr. SHAYS. The problem is that we are not paying our doctors enough. To start with, we don't have enough doctors in the system. That is the problem. And the reason is they are basically being asked to do it for less than their cost.

Mr. SMITH. Mr. Shays, if I may, in dental, in particular, Medicaid rules allow the States to pay rates.

Mr. SHAYS. I am not arguing what they allow, but you can be an advocate. I mean, you could be an advocate for a system that is causing bad health care and hurting our kids and hurting our elderly, as well.

Mr. SMITH. And, if I may, I think we described some of the things that we are doing in our testimony about trying to improve quality of care in the Medicaid system, in terms of the different States. There is a lot of talk about pay for performance. Medicaid actually has been doing pay for performance in a number of States and we are trying to help find the better models that work in the——

Mr. SHAYS. The better model would be just to pay someone to cover their costs. You are a government employee, aren't you?

Mr. SMITH. Yes, sir.

Mr. SHAYS. You work, you get paid, as a government employee?

Mr. SMITH. My salary is about $165,000, sir.

Mr. SHAYS. OK. Why don't we suggest that you work for $25,000. Just come, and we will be fair, you get, say, 10 percent, we will give you 20 percent, so you could make $32,000. Could you afford to go to work?

Mr. SMITH. Mr. Shays, again, I am agreeing with your point that——

Mr. SHAYS. You couldn't afford to go to work at $32,000 and yet we have doctors who are being asked to do the same thing.

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman, and his point is well taken.

The Chair at this point is going to recognize the gentleman from California who is the chairman of the full committee, Mr. Waxman.

Mr. Waxman, thank you.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Mr. Smith, I find it interesting that nowhere in your written statement did you refer to Deamonte Driver or his death from untreated tooth decay. He was enrolled for many years in the program you administer. He was entitled to dental services to relieve pain and infections and restore teeth, and he didn't get the services he needed, and died.

Has your agency conducted a review of this to determine what went wrong, why, what changes are needed to be made to prevent this from happening to anybody else who is also in Medicaid? If so, what were your findings?

Mr. SMITH. Mr. Waxman, the tragic death of a young child, we are certainly sorry for the loss and the family. I think there——

Mr. WAXMAN. I asked you if you did an analysis of what happened to him. Did you?

Mr. SMITH. I did not.

Mr. WAXMAN. OK. And did anybody in your agency conduct a critical incident review?

Mr. SMITH. I believe the regional office had discussions with the States in terms of trying to understand what the situation was. In terms of the individual, of course, those would be subject to any privacy rules.

Mr. WAXMAN. You left it to the State then?

Mr. SMITH. Again, I think——

Mr. WAXMAN. Let me go into this issue of the Federal Medicaid requirements. Federal Medicaid law requires that all children be given both routine dental services and any necessary treatments on a periodic basis. In 2004 the State of Maryland formally reported to your office that only 28 percent of the Medicaid children got any dental services at all. What action did you take when you received that information?

Mr. SMITH. That information, as I had said earlier, is information I think that has been known in the Medicaid program for quite some time.

Mr. WAXMAN. But you are running the Medicaid program at the Federal level. What action did you take?

Mr. SMITH. In terms of that particular—again, it is information that is already known within the Medicaid program at the State and the Federal level. There is an access problem.

Mr. WAXMAN. And you really did nothing. You received the information. For all 50 States, your own CMS data for 2004 show that the average number of Medicaid children who got any dental services at all was 32 percent. When you heard that is what is happening in the country, even though the program promises these services, what action did you at the Federal level running this program take?

Mr. SMITH. The enforcement tools, as I mentioned earlier, are to sanction the State financially, and where reimbursement rates are already low——

Mr. WAXMAN. Has CMS ever taken any action to enforce the Federal requirement that children get dental services?

Mr. SMITH. As I mentioned earlier, I have not. I don't know if my predecessors did.

Mr. WAXMAN. OK. While there is no minimum Federal payment rate for State Medicaid program reimbursing for health services, there is a statutory requirement that rates be "Sufficient to enlist enough providers so that care and services are available at least to the same extent they are to the general population."

GAO studies of Medicaid programs have repeatedly shown that reimbursement rates for dental services are very low. Other reports show that the overhead costs of a dental practice are about 60 to 70 percent of its billings. That means that reimbursement below that level is actually a net loss to the dentist. You don't expect the dentist to take on a Medicaid patient if they are going to lose money, do you?

Mr. SMITH. Mr. Waxman, as I have said, we believe that a variety of sources have been telling us and State legislatures and the Congress that access is a problem in the Medicaid program because of low reimbursement.

Mr. WAXMAN. But if a State is reimbursing dentists at a rate that is 50 percent of the average in the State, I assume you would agree that the State is violating the statutory requirement about sufficient rates?

Mr. SMITH. And, again, then it becomes an enforcement mechanism. Should I be taking money away——

Mr. WAXMAN. You agree it is a violation, then? then the question is what you do about it? Is that what you are saying?

Mr. SMITH. That is where enforcement comes. What action do I take against a State.

Mr. WAXMAN. OK. Well, has CMS ever taken any action to enforce that provision of the law regarding sufficient rates for dental services?

Mr. SMITH. I have not during the time that I have been there, Mr. Waxman.

Mr. WAXMAN. Has CMS ever taken any action to enforce that provision of the law regarding sufficient rates for any Medicaid service?

Mr. SMITH. Again, I can speak only while I have been there. I do not know what my predecessors did on how they addressed issues, whether they took sanctions against the State, financial penalties against the State for those reasons. I do know that the percentage of children on Medicaid receiving dental services is higher while we have been here than previously. I do know that.

Mr. WAXMAN. What we have is a Federal program where we spend an enormous amount of money. In fact, the Federal Government is going to pay $33 billion to help States purchase Medicaid services for nearly 30 million lower-income children enrolled in Medicaid, and there are a lot that should be enrolled but are not. Given this kind of level of investment by the Federal Government, don't we have a strong interest in assuring performance by the States and providers to receive the funds and to do the work and to get the children to get the care that they need?

Mr. SMITH. Which, again, the strategy that we have tried to pursue is through quality initiatives, through best practices, through things like pay for performance. In terms of managed care, I was a Medicaid director in Virginia, and we went to managed care. I don't know by what factor, but we tremendously expanded access not only to primary care physicians and dentists, but also specialists, as well.

Mr. WAXMAN. Wait a minute. Before you tell me all the good things you are doing, the national average for Medicaid dental visits by children in 2005 was 33 percent.

Mr. SMITH. Which is a——

Mr. WAXMAN. Two out of every three children enrolled in Medicaid received no dental services of any kind, preventive or restorative, during that year. So, as we have heard, Deamonte was among those children with no dental visits. Is 33 percent acceptable to you? If not, what specific steps is your agency going to take to improve this performance?

Mr. SMITH. Again, Mr. Waxman, I would say it illustrates that there is an access problem in the Medicaid program. I would also say that those percentages, while they are still not the levels that

any one of us like to see, they are higher than previously. States are showing improvement.

Mr. WAXMAN. Have you ever asked a State to increase their reimbursement levels? Have you ever told them they are breaking the law by not providing a sufficient reimbursement level to provide the care for those people who are eligible?

Mr. SMITH. Again, Mr. Waxman, enforcement is about taking financial penalties against the States, and——

Mr. WAXMAN. This is not even taking a penalty. This is simply telling them they are not living up to the law. Have you ever done that?

Mr. SMITH. Again, Mr. Waxman, I think everyone—Maryland did their own review and said we have an access problem. This is information that they know.

Mr. WAXMAN. They know it, but you are in charge of the program. You are in charge of over $30 billion of Federal funds. We want to be sure that when we are spending $30 billion of money that we are getting the job done, and the law says the job is done when every child has access to care, and we can't get that if we don't reimburse at a sufficient rate for people to provide the care.

You notice that the State of Maryland and probably most other States are not doing the job. Did you ever say to them you ought to do more?

Mr. SMITH. I think we have done a number of things to help States improve the quality of care for Medicaid children.

Mr. WAXMAN. Such as?

Mr. SMITH. Well, one thing we did in direct outreach to individuals—again, Dr. Clark talked about patient awareness in education. We have mailed out——

Mr. WAXMAN. If the patients are aware they are entitled to the benefit and they can't find anybody to give them the benefit, then what is the patient supposed to do?

Mr. SMITH. Again, there are a number of steps if the patient does not have access. There are——

Mr. WAXMAN. What steps?

Mr. SMITH. We spend——

Mr. WAXMAN. Tell me the steps.

Mr. SMITH. We spend——

Mr. WAXMAN. What would the young man's family have been able to do? What steps?

Mr. SMITH. Again, there are——

Mr. WAXMAN. Obviously, the guy running the Federal program doesn't seem to do anything about it. The people at the State level don't feel they have the ability to do anything about it. The law requires it. Should they call their Congressman and say pass a law to require that we get these services? Congressman would say yes, that is right, but we already have a law. What protection is the law if it is not giving them the benefits?

Mr. SMITH. The law says——

Mr. WAXMAN. You are in charge of running this program.

Mr. SMITH. Under the Medicaid law, Federal dollars follow State dollars. It is the State that must commit that dollar first.

Mr. WAXMAN. And if they don't shouldn't you tell the State they have a obligation to do something more than what they are doing?

Mr. SMITH. Again, Mr. Waxman, I think that as a system there are rights for the individual, there are systems of people to help give access. We spend $3 billion on what is called targeted case management, which is supposed to be simply connecting individuals to the services that they need. I think there is a wide variety of people who come into contact with individuals who need care, and, again, I think——

Mr. WAXMAN. Well, what you are saying is that somebody ought to provide the care for them for free?

Mr. SMITH. No, sir.

Mr. WAXMAN. You are saying it ought to be charitable?

Mr. SMITH. No, sir.

Mr. WAXMAN. Done charitably. But on the other hand we have a law that says they are entitled to these benefits, that the States are obligated to pay at reimbursement levels sufficient for people to take these cases, dentists in particular when we are talking about dental services, and if the State is not living up to the law the Federal Government should tell them you have to live up to the law, even if you don't take enforcement actions. But if you are not even telling them to live up to the law, they are not hearing from the people running the program.

We have gone around in circles and I think you should—are you proud of the job that Medicaid is doing when two out of three kids aren't getting dental services?

Mr. SMITH. I think Medicaid does a tremendous amount of good for the 30 million children who are enrolled in the Medicaid program.

Mr. WAXMAN. And for the one out of three that do get the dental care we are proud of it, but what about the two out of three that don't? Are we proud of that?

Mr. SMITH. I think, again——

Mr. WAXMAN. Are you satisfied with that?

Mr. SMITH. I think, again, Mr. Waxman, many different sources have identified what the issue is for access. As I said, Federal dollars follow State dollars, and the decisions that get made by the elected men and women who serve in State capitals are making decisions that are what is a priority, what gets funded——

Mr. WAXMAN. The chairman has been generous and we have gone around in circles. You are passing the buck. You were appointed by elected people in the Government of the United States to enforce the law with the States, but to tell the States they have to live up to the law, and what you have decided is since they aren't living up to the law you are not going to do anything about it because they already know about it.

I don't find that a very satisfactory answer, and therefore I have to hold the people responsible that appointed you to say to them they are elected officials and they are not getting the job done at the Federal level, and I have to hold you responsible, as well, because you are the one in charge of the program, and the least you could do is sometimes write a State a letter saying you are not doing a job if the reimbursement rates are so low. You ought to come to the administration and say Congress has to do something more because this program is not working for two out of three kids

when it comes to dental services, and I'm sure for many others in other services, as well.

I haven't seen any proposals from the administration other than to cut back on Medicaid, other than to give States more flexibility to cut back even more. I just think that the buck is not going to be passed on, as far as I am concerned. It is on your lap and I don't think you have done a very good job with it.

Mr. SMITH. Mr. Waxman, if I may, again, Medicaid as a system, a construct within the Federal system that has been built with the Medicaid program, but if you have built a car and you have designed it and you have engineered it, you still have to put gas in the tank to make it run.

Mr. WAXMAN. Yes, and you need people running——

Mr. SMITH. The gas in the tank is what——

Mr. WAXMAN [continuing]. The program who will make sure that the law is upheld. You are running the program. Federal law requires they get these services. Federal law requires that the States must put in reimbursement levels sufficient for people to provide the services. You can't say well, it is a whole system that is just not working. That is not an answer.

Mr. SMITH. But may I add——

Mr. WAXMAN. I don't know that the Chair—there are others who are waiting to ask questions. Maybe you can pass the buck during their time, but you have said about all you can say.

Mr. KUCINICH. Mr. Chairman, Mr. Waxman has as much time as you require.

Mr. WAXMAN. Do you have anything more to say?

Mr. SMITH. Again, I think that there are improvements that we have found in the Medicaid program through a variety of different strategies that we have been pursuing with the States as our partners. While you correctly cite the participation or the rates of which the percentage of Medicaid children are receiving dental benefits, they are higher than they were under my predecessor. Again, a number of sources, including the GAO, a number of sources have been telling that access is a problem, and I agree that access is a problem.

The key to improving access principally, from the provider perspective, is to increase reimbursement rates.

Mr. WAXMAN. Right, and Federal law requires that.

Mr. SMITH. And that is a State decision.

Mr. WAXMAN. And that is what?

Mr. SMITH. And that is a State decision.

Mr. WAXMAN. But Federal law says for the States to be a participant in the Medicaid program they have to provide enough reimbursement——

Mr. SMITH. That is correct, and to sanction them——

Mr. WAXMAN. Therefore, don't you have any responsibility in all of this?

Mr. SMITH. The sanction that I can apply against a State for failure for a State plan is to withdraw all of its Federal funding.

Mr. WAXMAN. Yes.

Mr. SMITH. That doesn't seem to be the right solution.

Mr. WAXMAN. So do you have a suggestion for changing the law?

Mr. SMITH. Not today, Mr. Waxman.

Mr. WAXMAN. OK. And do you have, other than the law is tough, any other reason to tell us why you are not enforcing the law? Do you feel you have an obligation to enforce the law? Couldn't you have written a letter to Maryland?

Mr. SMITH. Again, I believe, with the different reviews that have been done, and my staff has corrected me where I wasn't able to come up with the figure on how many reviews have been done, we have done 11 reviews from States based on their EPSDT reports. So we do go back into the States. We do reviews at all different types of or different parts of the program, and I think, again, while access is clearly an issue, it is an issue that the program, itself, at the State, the Federal level, and Congress, as well, has been aware of it for some time.

Mr. WAXMAN. Mr. Chairman, let me just conclude my comments by saying Federal law requires these services be made available to the children for dental services for the children that are eligible for the program. We now find for the most part two out of three kids are not getting any of the services that they are entitled to. Federal law requires that the States must pay a reimbursement level, and that is not happening. Federal law should require that the Department or the Center for Medicare and Medicaid make sure that when there is a case like this they do an investigation and tell the State they are not doing what they should be doing in that case.

I don't see any of those things having been done by CMS, and I must say, Mr. Smith, you are just giving me a lot of bureaucracy, a bureaucratic answer. It is a system. It is not working. It is just too bad. The States are not doing their job. I don't see any sense of responsibility, and I don't think that is the way the Federal Government ought to be operating.

Mr. SMITH. If that is your conclusion, sir, then I haven't done a very good job in trying to express the different ways that we have been trying to improve the quality of care in the Medicaid program. My statement reflects——

Mr. WAXMAN. I don't say that you are doing everything wrong, but I am saying you are not doing a good enough job. That is at the minimum when two out of three kids don't get pediatric dental care and they are eligible for it.

Thank you, Mr. Chairman.

Mr. KUCINICH. The Chair thanks Mr. Waxman for his participation. I note the gentleman, Mr. Smith, talked about Congress' responsibilities, and this subcommittee will endeavor to discharge those responsibilities.

Mr. Smith, in January 2001, there was a Dear State Medicaid Director letter about dental benefits under Medicaid. States received a letter from CMS noting that a number of States are not meeting participation goals for pediatric dental services, and then the letter goes on to say these States must take further action to improve access to these services.

Staff may have a copy of that. If you want to put up that slide, that would be appreciated.

The letter also——

Mr. SMITH. This is the January 18th letter? Is that what you are referring to, Mr. Chairman?

Mr. KUCINICH. Mr. Smith, I haven't finished my statement.

Mr. SMITH. I just wanted to make sure I understood——

Mr. KUCINICH. Let me finish my statement.

Mr. SMITH. OK.

Mr. KUCINICH. That was January 2001. That letter also said that the Federal Government was going to increase our oversight activities to assess State compliance with statutory requirements. It laid out a plan to have Federal reviews and visits to States with special attention to States in which fewer than 30 percent of the Medicaid children have received dental services. Forty-nine States responded to that letter, as shown in slide No. 2, 49 States responded. Among those who responded, 15 States reported that less than 30 percent of the Medicaid children had received dental services. Maryland was one of those States.

Mr. Smith, did you carry out the plan to have Federal reviews and visits to States?

Mr. SMITH. Mr. Chairman, those reviews were done. Every State except one submitted a corrective action plan based on that information.

Mr. KUCINICH. Did Maryland have a Federal review then and visit for oversight?

Mr. SMITH. I understand that Maryland did their own plan.

Mr. KUCINICH. So the answer is no? Did Maryland have a Federal review and a visit for oversight?

Mr. SMITH. Maryland did not have a review.

Mr. KUCINICH. Did every State do its own plan?

Mr. SMITH. Every State but one submitted a corrective action plan. Yes, sir.

Mr. KUCINICH. Did you take any actions to require Maryland to comply with the requirements?

Mr. SMITH. Again, I think the Maryland plan, itself, as I said earlier, Maryland since 1998 had identified the problems of access to dental in their own program. They set up Statewide advisory committees. They had, I think, a pretty comprehensive plan on how they intended to increase access.

Mr. KUCINICH. Did you take any actions to require Maryland to comply with the requirements?

Mr. SMITH. Again, Mr. Chairman, I think the information was the State was taking corrective action, had its own plan for what steps it would take.

Mr. KUCINICH. Did you take any actions to require any State to comply with the requirements? There is a difference between States saying we are going to straighten this out and the Federal Government reviewing it and saying look, you haven't straightened it out, here is what we want you to do. Did you take any action on that?

Mr. SMITH. Again, we have taken a number of actions. We meet regularly with the Medicaid directors on a State basis. There are 10 regional offices across the country. There are a number of different ways we have contacts with States at the national level, at the policy level. We meet twice a year with the Medicaid directors. We have technical assistance groups. Again, those are more on the policy side of things that apply to all States.

Mr. KUCINICH. So how many States now meet their legal requirement to have adequate dental services?

Mr. SMITH. Again, Mr. Chairman, I think the increase in access to dental services is lower than, again, what we—it clearly continues to show us there is an access problem in Medicaid.

Mr. KUCINICH. Wait. Wait. There is an access problem. We can all agree with that. But what about the oversight and enforcement from your office? I mean, there are legal requirements here.

Mr. SMITH. And, again, they——

Mr. KUCINICH. If they don't meet those requirements, aren't you supposed to take action under statute?

Mr. SMITH. It is a rather big step, which is saying they are not in compliance with——

Mr. KUCINICH. How many aren't compliant?

Mr. SMITH [continuing]. The State plan, which is to take all of their Medicaid dollars away from them.

Mr. KUCINICH. But how many are compliant?

Mr. SMITH. In terms of access——

Mr. KUCINICH. No. How many are compliant in terms of the law with respect to the legal requirement to have adequate dental services? How many are compliant? Isn't the answer zero?

Mr. SMITH. Mr. Chairman, I think you are looking at——

Mr. KUCINICH. I am looking at your responsibility, sir. How many are compliant? How many States are compliant?

Mr. SMITH. The use of dental services varies for a wide variety of reasons, including the individuals seeking the dental services in the first place.

Mr. KUCINICH. How many are compliant?

Mr. SMITH. I have not found any State to be out of compliance, Mr. Chairman.

Mr. KUCINICH. Are you telling this committee that you are prepared to produce for this committee documentation that 50 States are meeting the legal requirement to have adequate dental services? Are you telling us that under oath?

Mr. SMITH. I think you are——

Mr. KUCINICH. I don't want to have any misunderstanding about this. I am just going to give you another chance to answer the question. Are you telling us that?

Mr. SMITH. I think to some extent we are looking at this two separate ways. In terms of the individual, their right to access dental benefits, they are entitled to those benefits. The extent to which that individual has rights of appeals, the extent to which health plans are operating within the Medicaid law and within those requirements, I believe I can tell you that those things, in fact, are present.

Using a measure of how many children sought and received dental care is a different measure. Those measures clearly say we have an access problem. The reason we have an access problem, I think as I said before, Dr. Clark pinpointed those reasons very well.

So in terms of compliance with the parameters of the Medicaid program, and again States have responsibilities that they certify to us that certain things are being met, that those rights and responsibilities are present for use by the beneficiaries, the constructs I can say I do believe those are present in all of the States.

Using a measure, though, to say how many children are reported to have received services is a different measure, and I cannot say,

by using that measure, that the Medicaid program is in full compliance.

Mr. KUCINICH. So, to answer my question, when I asked how many are compliant, is the answer zero?

Mr. SMITH. By using the measure that you are using, yes, Mr. Chairman.

Mr. KUCINICH. Well, that is what I wanted to find out, and I am going to ask staff to develop a series of questions to be quite specific State-by-State to followup on determining compliance and specifically reviewing with respect to utilization goals.

I want to pick up on a question that Mr. Waxman had about changes, about reimbursement for dental services to children under Medicaid and the Guide to Children's Dental Care and Medicaid. The original draft contained seven full pages about reimbursing dentists adequately under Medicaid for taking care of children. The draft contained statements such as "a substantial gap in funding levels exists in most States between current Medicaid dental program allocations and market-based requirements," and average Medicaid reimbursements "may not cover the cost of providing services and are not likely to be viewed as positive incentives for dentists' participation."

Now, someone took these statements, and, as Mr. Cummings pointed out, many more pages about the inadequacy of Medicaid payment rates out. Why?

Mr. SMITH. Again, Mr. Chairman, as I was trying to draw on my memory to address Mr. Cummings, we are not disagreeing. I am not disagreeing today. I think that the access about dental rates is a core issue as to why we have an access problem.

Mr. KUCINICH. You agree with that, but there was a document produced. Those statements were taken out, which actually, if I am right, Mr. Cummings, these undermine the concern that people would have about whether or not dentists are being adequately reimbursed——

Mr. SMITH. Again, I——

Mr. KUCINICH. Excuse me. I am having a colloquy—and therefore would cause a lack of participation. Wouldn't you agree, Mr. Cummings?

Mr. CUMMINGS. I would agree 100 percent. I was just sitting here thinking, Mr. Chairman, this is a very sad state of affairs when the very people who are supposedly making sure that a system works and works well then take out the very words that are the essence of—it is like the Bible for making sure it works well. I mean, something is wrong with this picture.

I yield back.

Mr. KUCINICH. I would just say that I think this committee needs to probe a little bit more deeply into why was this taken out. Do you have any idea? Did you know this was taken out?

Mr. SMITH. I remember yes, I did review it.

Mr. KUCINICH. Were you the person who excised it?

Mr. SMITH. Again, I am trying to draw on my memory of the dental guide, itself, in terms of the purpose and the use of it, and I do recall having discussions and making changes, myself, that the guide was being—the purpose of the guide was for a particular rea-

son, that reimbursement rates didn't—they were not a part of the purpose of the guide, itself, is my recollection.

Mr. Chairman, yes, I did review the guide. Yes, I did make edits to the guide. And I do remember that and I will be happy to go back, but my recollection is the guide was for one thing and the financing pieces seemed to me that they weren't appropriate to what the guide, itself, is being used for.

Mr. CUMMINGS. Would the gentleman yield, please?

Mr. KUCINICH. Yes, I will yield.

Mr. CUMMINGS. Mr. Chairman, you just talked about or asked Mr. Smith some questions about things that have been taken out, and, Mr. Smith, you said just now that some of the things were taken out because I guess you felt that, although you agreed with them, you thought that they were inappropriate for this guide; is that correct?

Mr. SMITH. For the purpose of what the guide was to be for.

Mr. CUMMINGS. And what was the purpose of the guide? I guess that is the better question.

Mr. SMITH. Again, I am——

Mr. CUMMINGS. Wasn't it to lay out the States' responsibilities for meeting Federal regulations? Wasn't that the reason?

Mr. SMITH. That is not my recollection of what the guide was for.

Mr. CUMMINGS. Well, what is your recollection?

Mr. SMITH. And I——

Mr. CUMMINGS. Don't tell me you don't remember, please. And let me tell you why I am saying that. I have never said that to a witness ever in a courtroom or since I have been here in the Congress 11 years, but you just sat there and you just told us that you made changes, you participated in the changes because you felt like certain things were not appropriate for this. And now please don't tell me you now forgot. Did you?

Mr. SMITH. Mr. Cummings, the guide, itself, for the purpose of the guide, if I recall—and I might—the purpose of the guide was not about explaining financing and reimbursement about Medicaid. It was about, if my recollection is, it was about quality and measures and of that nature.

Mr. CUMMINGS. I understand that, but let me ask you this question: the original draft had these words: "Improvements in Medicaid will cost more—" listen to this—"because more children will be served and have more of their treatment needs met, but that as children receive care—" listen to what they are saying—"unmet need should decline and ongoing costs should be less." That was in the original.

But it went on. It said, "Dental program improvements can be expected to yield significant savings in treatment costs on an individual level and reduce the overall need for investments in safety net clinic capacity."

Those words were also taken out. Do you remember that? Did you participate in that, too?

Mr. SMITH. I don't remember the specific words, Mr. Cummings. I did participate in editing the guide, and the guide was about clinical information. Financing, I am trying to recall my rationale that discussing the reimbursement side wasn't regarding clinical standards.

Mr. CUMMINGS. Yes, but this piece—and I will yield back, Mr. Chairman, in a second—but this piece here sort of goes to it is talking about cost and reimbursement, but it is also talking about being helpful to children, to children that we, as adults, are supposed to help and provide for, the children that you are supposed to be helping through your agency.

What I am saying to you is that it seems like this goes to the essence of making sure that they are treated, because what it is basically saying is that we do these things and there is less—you can pay me now or you can pay me later scenario. But the one big factor is at least the children are healthy, as opposed to—because when we pay later we have situations like this young man, Mr. Driver.

Mr. SMITH. Mr. Cummings, I agree with you. Health care is driven in many respects by under-utilization of services that are preventative, that will make that investment today will save you money down the road as well as improving the quality of care.

Mr. CUMMINGS. Ms. Norris, I think it was, said something in her testimony. This is my last question. She said that we need to have a campaign, your organization needs to have a campaign about folks making sure that kids get dental care early.

Mr. SMITH. Yes.

Mr. CUMMINGS. Do you do any of that kind of thing now?

Mr. SMITH. Mr. Cummings, we have mailed out, we have provided more than 50 million copies. This is direct to Medicaid families.

Mr. CUMMINGS. OK.

Mr. SMITH. This is the first year of life. There is one for every month. This is for the parents for what they need to do for their child. At month six we talk about the need for——

Mr. KUCINICH. Excuse me. I am going to ask if staff could obtain what the gentleman is saying and we could just take a look at it.

Mr. SMITH. Sure.

Mr. CUMMINGS. I yield back, Mr. Chairman.

Mr. KUCINICH. No, continue, Mr. Cummings.

Mr. CUMMINGS. I mean, Ms. Norris is a person who, as you heard her say, I mean, that is what she does. She helps folks get care. And she sat at that table, and when we asked what should your organization be doing she said apparently she believes that you should be doing more of getting the word out and encouraging people.

Mr. SMITH. To my knowledge, Mr. Cummings, this is the first time the Federal Government has ever produced something like this for beneficiaries to help them to understand the health care for their children. As I said, we have distributed more than 50 million copies of this. This is the series, the first year of life, so there is one for every month. In month six it starts talking about the importance of oral health care.

Again, we are in passionate agreement about the need for greater patient awareness of the importance of oral health.

Mr. CUMMINGS. I yield back.

Mr. KUCINICH. The Congresswoman from California has been very patient. I wish to yield to her such time as she may consume, a minimum of 10 minutes. You may proceed, Congresswoman.

I want to say that at the conclusion of your questioning I have a followup question relative to testimony based on a document just handed to me, so if you could just go ahead.

Ms. WATSON. All right, because I am taking my discussion in a little different direction, you might want to go ahead now, since it is relevant to this discourse. I want to talk about another aspect.

Mr. KUCINICH. OK. That is fine, and I appreciate the indulgence of the gentlelady.

In response to my question, Mr. Smith, relative to how many States were, in fact, in compliance, you bifurcated your answer. You gave, on the one hand, if you are talking about financing of dental services, and on the other hand if you are talking about the organization of dental services.

Now, isn't it true that CMS issued a contract to the American Academy of Pediatric Dentistry for the purpose of reviewing the original guide?

Mr. SMITH. Yes, sir. I believe that is correct.

Mr. KUCINICH. And didn't they issue a contract for developing a revision for use by stakeholders concerned about children's oral health and Medicaid?

Mr. SMITH. I don't remember the timing and when, but I believe that was concluded in 2004.

Mr. KUCINICH. And isn't it true that the contractor was requested to incorporate information on not only the organization but on the financing of dental services, dental work force and capacity and accountability?

Mr. SMITH. I don't know what the original contract called for, Mr. Chairman. I am sorry I don't.

Mr. KUCINICH. I want to submit into the record a preface page from a Guide to Children's Dental Health and Medicaid and to help you to recall that the operative language here is that the contractor was requested to incorporate information on the organization and financing of dental services, dental work force and capacity and accountability, along with other administrative issues which might be of assistance to State Medicaid agencies and stakeholders in their efforts to improve access to oral health services for children. I want to state, I mean, there is an obvious significance to this.

If, in fact, CMS issued a contract to the American Academy of Pediatric Dentistry to incorporate information on the financing of dental services in the report and if, in fact, we see issues relating to finance and the ability for reimbursement, for example, for dentists taken out of the final report, we have reached one of these teachable moments, Mr. Smith.

I want you to square for this committee how in the world you requested a contractor to provide information on the financing of dental services and then you simultaneously took out of the contractor's report information that was absolutely critical for States to be able to make an assessment about the delivery of pediatric dental care to the children of the United States.

Mr. SMITH. Mr. Chairman, I didn't write the original contract. I didn't review the contract.

Mr. KUCINICH. I am going to withdraw the question. I have to say, in going along with Mr. Cummings, this is really an extraordinary hearing because the response that we are getting is so ob-

tuse that it is non-responsive, and, rather than waste the time of this committee with non-responsiveness, I am going to go to Ms. Watson.

Thank you.

Ms. WATSON. Mr. Chairman, I am sorry that Mr. Waxman left because I wanted to commend you and Mr. Waxman for the oversight. I have been here going on my 6th year, and we never had these kinds of hearings. We were not fulfilling our responsibility to oversee the agencies that we fund.

The reason I can be patient is because I was listening to the responses, and it comes to me that in this country we set priorities, and we talk about homeland security. It is not about the land, it is about the people on the land. And when we sit up here at a Federal agency and allow a young man to die because he didn't get the kind of dental care, it is our responsibility. So I am pleased that we are trying to get down to where the flaw is in this system. We just have not set a priority on the health of Americans.

There is another issue that I wanted to bring up. I have been championing this issue for decades. When I was the Chair in California of the Health and Human Services Committee, we learned that mercury is a neurotoxin. What does that mean? That means that it poisons the body, and particularly the brain.

I don't know if you out there listening—and maybe Dr. Clark in the back knows this—the amalgam fillings that most people, and people who you serve, Dr. Clark, that silver filling is 50 percent mercury, and mercury is the most toxic substance in the environment. Guess what? We put it into your mouths. Regardless of how tightly encased the mercury is, it still can escape. We had a spill last year in Virginia and we had to close three high schools down because kids were playing with mercury. It balls up and it bounces down and it is fun, but it is poisoning.

With mercury in your amalgam, it goes up in your T-zone. Hello? It is always emitting. It goes up into your T-zone. It is like lead. It starts to destroy the meninges. That is the thin skin over the brain. And we allow it.

And so for 15 years in California my legislation instructed the Dental Board to come up with a pamphlet that could be given out to the patients. It took 15 years to get it done, and we didn't get it done until I came here, put some pressure, held some hearings in Los Angeles. We held hearings and I joined in a nonpartisan way with my colleague, Dan Burton, and we finally got them to do that.

So I am a sponsor, and you need to know this is coming down the line, Mr. Smith. I am a sponsor of legislation that would ban the use of mercury dental amalgams immediately in children and pregnant women and phase it out for the rest of the population over a period of 2 years.

The number of mercury-free dentists—and they are becoming aware—is slowly rising in this Nation. In fact, Clinical Research Associates of Utah State in a recent survey said roughly one-third of dentists licensed in the United States now have mercury-free practices.

In 2005 and 2006 in a survey conducted by the Consumers of Dental Choice, it found that all of the 31 States that responded do

allow their Medicaid patients a choice of either dental amalgam or non-mercury fillings. But none of the States, zero, had a program to publicize to patients that they have a choice.

I should also note that dentists with mercury-free practices have refused to participate in their State's Medicare programs because they may still believe that State Medicare rules would only allow them to use dental amalgams.

Mercury is a neurotoxin and we still allow it to be used, so my bill would require the banning of mercury amalgams in children under 18 and in pregnant women and in lactating mothers because of the toxicity of mercury amalgam.

So my question to you: are you doing anything to educate the dentists across the 50 States to the dangers of using mercury amalgams, Mr. Smith?

Mr. SMITH. Congresswoman, you are bringing up a subject that is entirely new to me.

Ms. WATSON. OK. Fair enough. But you see that is my thing. I am passionate about it. We fought for it in the State of California. Our Medicaid program is MediCal, and during my tenure there, 17 years as the Chair, I was there 20 years, but 17 years as the Chair, we added 32 to 34 benefits that were not required under Medicaid. I am sure since I have been gone these 6 years or so they have added others, because our people demanded it.

I think the people in the State of Maryland and across this country ought to demand more from their Federal Government in terms of these programs we have created.

That is my statement. I wanted to get that out to you. It is a heads-up. Watch for my bill. I intend to have it signed into law, because I have the other side working with me on this in the best interest of health in America.

Thank you, Mr. Chairman. I am going to go to the floor. We have a vote.

Mr. KUCINICH. I thank the gentlelady.

Before I dismiss the second panel, I would just like to thank Mr. Cosgrove for his attendance and appreciate your being here. We appreciate Mr. Smith, as well.

I would like to just let Mr. Smith know that this committee will be giving you a detailed request to produce all documents relating to the editing of that particular guide and any type of communication that was in-house or that you received in e-mails or such. We would ask the committee staff to communicate with Mr. Smith's office to make sure that you could get this to this committee expeditiously.

We want to thank you for your participation here today. The second panel is dismissed.

We will proceed with the third panel for their opening statements, and then we are going to recess for votes. Thank you very much.

This is the third panel of the Domestic Policy Subcommittee hearing on evaluating pediatric dental care under Medicaid.

This panel includes: Dr. Allen Finklestein, who is a former U.S. Army Captain who is assigned to the Post-Preventive Dental Office at Fort Bragg, NC. Dr. Finklestein has been a practicing dentist for more than 35 years, with a specialization in periodontal prosthesis.

His professional memberships include the Rhode Island Dental Association and the New Jersey Dental Association, the Essex County Dental Association, and Alpha Omega Dental Association. Currently, Dr. Finklestein serves as chief dental officer of AmeriChoice. This business segment within United Health Group is exclusively focused on serving beneficiaries of Medicaid and the State Children's Health Insurance Programs [S-CHIP]. AmeriChoice serves over 1.4 million Medicaid members, including children in 13 States.

We will be hearing from Ms. Susan Tucker, who recently rejoined the staff of the Department of Health and Mental Hygiene. She is executive director of the Office of Health Services for the Maryland Medicaid Program. The Office of Health Services is responsible for developing and implementing policy relating to Medicaid covered services. Ms. Tucker has 19 years of experience with State Medicaid programs. She has special expertise in maternal and child care programs within Medicaid.

Finally, we will hear from Ms. Jane Perkins, who is the legal director at the National Health Law Program, a public interest law firm working on behalf of low-income people, children, people of color, and individuals with disabilities. Ms. Perkins focuses on public insurance and civil rights issues. She engages advocacy on these topics, manages the National Health Law Program's litigation docket, and has written numerous articles on Medicaid and children's health coverage.

I would ask the witnesses to please rise. It is the policy of this committee to swear in all witnesses before they testify.

[Witnesses sworn.]

Mr. KUCINICH. Let the record reflect that all of the witnesses answered in the affirmative.

In order to provide the witnesses with the full opportunity for uninterrupted testimony, we are going to take a recess right now. Unfortunately, I have been informed that Congress has at least 1 hour and 15 minutes of votes, so if there is any difficulty in any of the panelists staying you should let our staff know, but I would ask you to stay. I am going to make sure that Members of Congress know that you are still present so we can give them the opportunity to participate.

I am grateful for your being here. I thank you for your patience.

This committee will stand in recess for 1 hour and 15 minutes, which means that we will be back here at approximately 20 to 7. Thank you.

[Recess.]

Mr. KUCINICH. The committee will come to order.

This is the Domestic Policy Subcommittee. Our hearing today is on evaluating pediatric dental care under Medicaid.

We are now beginning our third panel. I have been informed that due to the extenuating circumstances of the congressional schedule with so many roll call votes that we have now encroached into someone's travel time. What I want to do for the witnesses, Ms. Perkins, if you have a flight to catch I would be happy to have you read your testimony. Did you have a flight to catch? Is that correct?

Ms. PERKINS. I now do tomorrow morning.

Mr. KUCINICH. OK. Tomorrow morning? Tonight?

Ms. PERKINS. Not any more. I am good.

Mr. KUCINICH. Oh, it is tomorrow? OK. Great. We are not going to be here until tomorrow morning. I promise. I will promise you that. This is a long hearing, but we are not going to go that long.

Well, then, let us begin, if we may, with Dr. Finklestein. Thank you, Doctor. Please proceed.

STATEMENTS OF ALLEN FINKLESTEIN, CHIEF DENTAL OFFICER, UNITED HEALTH CARE; SUSAN TUCKER, MBA, EXECUTIVE DIRECTOR, OFFICE OF HEALTH SERVICES, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE; AND JANE PERKINS, LEGAL DIRECTOR, NATIONAL HEALTH LAW PROGRAM

STATEMENT OF ALLEN FINKLESTEIN

Dr. FINKLESTEIN. Good evening, Mr. Chairman. Thank you for the opportunity to testify here today.

I am Dr. Allen Finklestein. I am the chief dental officer for AmeriChoice, which is part of United Health Group. We serve the Medicaid population. I have also been a practicing dentist for 37 years. As a health care professional, I take care and pride in treating people. That is why I am deeply moved by the death of Deamonte Driver.

I want to add my personal condolences to the family. I hope with all my heart that we can keep this from ever happening again.

I have worked with governments for many years. As a young Army Captain, I helped design a preventive program to avoid dental emergencies in Vietnam. More recently I was on the forensic team that helped identify victims of September 11th. But, first and foremost, I am a dentist, and a dentist always has been trained to fix problems.

Now we need to take a broader approach, a move to a preventive model. We have heard today about access to dental care, but access is not the only problem. We have to get past all barriers and deliver dental care.

Clearly, one barrier is poverty, itself. For family S with Medicaid, dental care is a lower priority than food, shelter, and safety. You have heard today that some dentists don't want to take new Medicaid patients. The reimbursements may be one of the reasons. But even more of a factor that I find when I build networks is missed or broken appointments. Lots of dentists are willing to treat my children, but if the child doesn't show up the dentist has lost a slot and missed an opportunity to treat another patient.

I want to help every child, but I can't help them unless they sit in my chair or my colleague's chair.

The AmeriChoice approach is to help Medicaid patients get their appointments. Our multi-lingual call center is staffed around the clock, and the phone number is clearly written on every member's card. It is an 800 number. The call center can help make appointments, even arrange for transportation to the office and back home. We also reach out by mail and by phone, but that doesn't help if the member doesn't have a phone or a fixed home.

So AmeriChoice is developing innovative ways to connect with our members. We are collaborating with everyone who touches the

lives of these children, including government agencies, schools, community organizations, parents, and health care providers. This collaboration is not some hypothetical concept. It leads to real benefits in the lives of real people.

Rhode Island is a great example. We worked with the State to create a program called Right Smiles, which now serves all of the Medicaid population 6 and under, all 32,000 of them. By stressing preventive care, we hope to start them on a path of a lifetime of oral health. Now the State wants to expand this program to reach older children.

In Maryland and other States, we partner with local dentists to run screenings in schools. Each child gets a toothbrush, dental education, and, above all, a dental baseline examination.

Elementary schools are incredibly important. I may look young, but nearly 60 years ago I had to have a dental checkup before I could enter kindergarten or return to any grade subsequent to that. We are working with schools in Patterson, NJ, which now require an annual dental checkup before a child can return to school. We partner with retailers adjacent in Maryland and elsewhere. We give parents a $10 gift certificate for taking a child to the dentist.

A family with Medicaid is much more likely to see their physician than to go to a dentist, so we are working with Brown University and Hasborough Hospital in Providence to teach early signs of dental disease to physicians.

What we are doing in Rhode Island can be replicated in any State. We are eager to help. These partnerships are good for patients, they are good for the community, and they are good for AmeriChoice. If I can treat a young child in my dental chair, that child is so unlikely to have a dental emergency later.

Surgeon General Satcher called it the silent epidemic. As you can see from today's testimony, it is not so silent. We have to partnership. We have to collaborate together. This disease is totally preventable and only when we can do preventive measures.

Thank you for your time. I appreciate all that the committee has done.

[The prepared statement of Dr. Finklestein follows:]

Testimony of

Dr. Allen Finkelstein
Chief Dental Officer

AmeriChoice
A UnitedHealth Group Company

For the

Domestic Policy Subcommittee
Committee on Oversight and Government Reform

"Evaluating Pediatric Dental Care under Medicaid"

2154 Rayburn HOB – 2:00 P. M.

Wednesday, May 2, 2007

Introduction

Thank you Chairman Kucinich, Representative Issa, and other distinguished members of the Committee for the opportunity to testify today about the important role of pediatric dental care for Medicaid-eligible children. I am Dr. Allen Finkelstein, and I am Chief Dental Officer of AmeriChoice, which is UnitedHealth Group's business unit exclusively committed to serving beneficiaries of Medicaid and the State Children's Health Insurance Program (SCHIP).

I am also here today as a practicing dentist of more than 35 years. Like any health care professional, my role is to take care of people, and I feel a profound sense of loss at the untimely death of Deamonte Driver in Maryland. His death was a tragedy that saddens all of us.

Out of this tragedy, all of us owe it to our children and our communities to take a closer look at how children with Medicaid receive dental care, in Maryland and across the country. At AmeriChoice, we remain fully committed to working with parents, communities and the government to ensure that timely dental care is not just *available* to our most vulnerable children, but that it also is *delivered* to them.

UnitedHealth Group provides a diverse and comprehensive array of services to 70 million Americans. Since 1989, AmeriChoice has been dedicated to helping Medicaid-eligible children and their families obtain the preventive and acute health care services they need – including dental care; treatment for chronic conditions; and attention to unique and often complex health and well-being issues. We have earned a reputation as an innovative developer of health care solutions in many of the states where we operate.

I have devoted my whole career to preventive dental medicine, beginning in 1969 as a U.S. Army Captain. When I was at Fort Bragg in North Carolina, there were so many dental emergencies in Vietnam that the Army asked me to develop a stateside program to increase preventive care and decrease dental emergencies among troops *en route* to Vietnam. Nearly 40 years later, it is unfortunate to be here today speaking to you about similar, preventable dental problems. However, in the Army, my patients showed up for their appointments – with 100 percent attendance. By contrast, the Medicaid patients we are discussing today often face challenges that make it difficult to take advantage of the full spectrum of dental care benefits available to them.

Concurrent with my work at AmeriChoice, I continue to see patients on the weekends in my Great Neck, New York practice. My comments today are informed by a few simple, but important beliefs, which I share with AmeriChoice and which are the chief reasons I work for the Company:

- Dental care is critical to overall well-being and should be on a par with other aspects of health.
- A person's health must be viewed holistically, and health care must be approached in an integrated way.
- Patients should always come first and be cared for personally as individuals.
- Medicaid beneficiaries face challenges in accessing adequate health care. It takes flexibility and a willingness to try new and innovative approaches to make health care work better for them and for the providers who treat them.
- And, finally, to understand your patients, you need to stay in close touch. I am grateful that AmeriChoice recognizes the value in this connection to members by enabling me to continue to see patients and work one-on-one with providers and communities across the country.

Today, AmeriChoice serves more than 1.4 million members in health plans through Medicaid and SCHIPs in 13 states. Our participation in the Medicaid program is fundamental to our parent Company's core mission: to support the health and well-being of individuals, families, and communities. As Chief Dental Officer at AmeriChoice, I personally review more than 4,000 dental cases each month to ensure the highest and most equitable standard of care for our members.

With all of this in mind, I believe we can offer important perspectives based on our experience. While this hearing has been convened ultimately as a result of a tragedy that occurred in the State of Maryland, we appreciate the opportunity to discuss the issues related to providing pediatric dental care to Medicaid-eligible children nationwide, and to consider potential solutions to bridge gaps. We would like to commend Chairman Kucinich and members of the Subcommittee for holding this hearing and also Chairman Dingell and other Members for proposing thoughtful legislation to address the issues.

Driving Increased Utilization of Available Services, Fostering Holistic Care

There are two significant issues that affect the provision of dental care to Medicaid beneficiaries and the uninsured – access and utilization. Much of the recent public debate has centered on access to providers. We are focusing our testimony today on utilization, which has received far less attention. A child may have access to a network of willing dentists, but nothing meaningful happens until the child sits in the dentist's chair.

From our experience, the most pressing challenges in increasing utilization is educating families about the importance of dental care, engaging providers and parents in a proactive and holistic approach to children's health, and encouraging the use of the wide range of dental services and benefits available. Driving increased utilization by the most vulnerable families will require a strong shared commitment and collaboration from all involved, namely government agencies, schools, community organizations, parents, insurance companies and the health care community. We all need to be in this together.

I will focus my remarks today on four key areas:

1. The importance of preventive dental care to children's general health
2. Barriers to delivering dental care
3. The AmeriChoice approach
4. Potential broad solutions

The Importance of Preventive Dental Care in Children

We have all seen how poor dental health can lead to much greater physical health issues. Addressing dental problems early in children's lives can make a meaningful difference in their growth, development, and future adult health.

Tooth decay is America's most prevalent chronic childhood disease, more widespread than asthma and diabetes. Of the 4 million children born each year, more than a half of them will have cavities by the time they reach second grade, according to the Children's Dental Health Project. For lower income populations, the situation is more severe. In the 2000 "Oral Health in America Report," U.S. Surgeon General David Satcher called dental and oral disease a "silent epidemic," disproportionately affecting poor children. Children in poverty are more likely to experience dental decay and cavities, and those children without dental insurance are three times more likely to have dental needs than children with either public or private insurance. An estimated 20 million children in the United States do not have dental insurance.

This is particularly unfortunate, because dental disease is largely preventable and treatable. Preventive treatment is cost effective and can ensure against more expensive ailments and unnecessary disease. Proper care and education must start early, and reinforcement must come from all areas of a child's life, including dentists, medical doctors, parents, and schools. Since pediatricians and other child health professionals are far more likely than dentists to encounter parents and children with Medicaid, it is essential that doctors reinforce, educate and give priority to dental care and oral hygiene. Care of the teeth needs to be linked with care of the rest of the body.

Whenever I must extract a diseased tooth from a child, I count it as a failure of the system. I've dedicated my career to educating parents, practitioners, and insurers on these preventable problems.

Barriers to Delivering Dental Care to Children with Medicaid

There are many barriers contributing to this silent epidemic, including a lack of adequate education and understanding about the detrimental effects of poor oral health. More needs to be done to educate the public and those in the medical field to put an end to the epidemic.

Socio-economic factors: In many cases, families with lower incomes have needs that compete with and take priority over adequate dental care. Dental hygiene often takes a back seat to basic daily survival needs such as food, shelter and child care. These issues often are compounded by language and cultural barriers and the complexities inherent in administering a multi-faceted program such as Medicaid.

Dental care not prioritized: Common misconceptions and out-of-date beliefs about dental health are rampant. Many parents and community leaders do not understand the importance of dental health and its connection to more serious health issues. For instance, many parents think taking care of baby teeth is not integral to overall dental hygiene, and as a result, the dental health of a toddler growing into a child is compromised. Once again, this is where pediatricians, insurers, school systems and government agencies can be of enormous assistance.

If parents are not educated about the importance of oral health, or if they have more pressing life needs, dental services will not make it to the top of their list.

Other important factors also contribute to low utilization and dental care delivery problems, including difficulty in communicating with members and the declining number of dentists generally.

Communication hurdles: Health plans report challenges in communications with Medicaid beneficiaries. Because many people on Medicaid have transient living situations and frequently lack telephone service, regular communication with beneficiaries is impeded. At AmeriChoice, we have experienced a high rate of returned mail in mailings to Medicaid beneficiaries, for example.

Another significant issue health plans experience is lack of understanding about the reasons children or whole families are dropped from state Medicaid rolls. As the health insurer, we receive a data feed from the state that tells us who has dropped off of Medicaid, but we rarely know why. It could be the result of a rise in income that leaves a family no longer eligible for Medicaid, or it could be that a homeless family has moved from one shelter to another and did not receive the paperwork for renewing eligibility. Even if the paperwork arrives safely, more basic concerns may take precedence over navigating the administrative process. Current Medicaid rules prevent us from contacting a family once they are dropped from Medicaid and from our program.

Dental Provider Participation: Integral to this discussion are the issues related to the providers themselves.

The United States is experiencing a shortage of dentists and people entering the dental field, and some dental schools have been closing. Twenty percent of current dentists are expected to retire in the next ten years, and there are an insufficient number of replacements in the pipeline. Moreover, the number of people electing to go into pediatric dentistry as a specialty has diminished. It would take a significant and immediate increase in dental school enrollments to reverse the overall trend.

Support and incentives for dental providers to treat children with lower incomes are also insufficient. Many dentists find it too difficult to treat children six and younger, and report a high percentage of missed appointments with Medicaid beneficiaries.

To serve the needs of Medicaid beneficiaries effectively, we must also address the needs of the providers who care for them.

The AmeriChoice Approach

AmeriChoice is a leader in providing health and dental care benefits to the nation's most vulnerable populations because we offer a holistic approach to health, involving members, families, providers and government and community organizations to ensure continuous and effective care.

Medicaid is broad and deep in what it provides beneficiaries, although there are some variations from state to state. Our package for Medicaid beneficiaries often goes beyond the standard Medicaid mandates. We base our benefits on the philosophy of increasing utilization of preventive services. Members are less likely to need expensive and sometimes traumatic specialty care if they maintain the best health possible. To that end, we provide case management, care coordination and customer service.

For example, AmeriChoice offers to its Medicaid members:

- A member services call center, staffed around the clock, for referral services, assistance in making medical and dental appointments, and general information on where to find medical care. The toll-free number for the call center is printed on the back of the membership card issued to every member.
- There is also a second call center specifically dedicated to dental services, which is staffed from 8 a.m. to 8 p.m., Monday through Friday.
- For chronically-ill members, we assign a professional case manager, either a registered nurse or social worker, to assist members in coordinating the best care possible.
- Coordination of transportation to and from medically necessary appointments, including dental appointments.
- Health education prevention materials including quarterly newsletters and targeted mailings to keep members informed of important and timely health matters.

Education and awareness building is also critical to implementing our integrated approach to care. We are supporting education and cross-training programs for pediatricians and dentists about the clinical aspects of dentistry and the socioeconomic issues facing Medicaid beneficiaries. For example, we are educating pediatricians to speak knowledgeably to a mother about the importance of not leaving a child unattended with a bottle of milk or sugary drink, as it causes enamel erosion and potential tooth decay.

AmeriChoice and Innovation

One of our most significant achievements in the area of dental care has been the creation of a strong dental provider network. Noteworthy is the State of Maryland, where we have more than 100,000 Medicaid members. The State requires a minimum of one network dentist for every 2,000 members in a service area. In Maryland's Prince George's County, we have a much better ratio than that, at 1 dentist for every 250 members.

No matter how robust our network is, it is only effective if the services are used. We have increased utilization by our hardest-to-reach members by creating innovative programs that address unique and specific needs. We firmly believe we can increase visits to the dentist if we join forces with communities, state governments and providers.

In Maryland, there have been dramatic improvements in utilization of dental services by Medicaid beneficiaries. In 1997, before health plans began administering Medicaid programs, dental utilization was less than 20 percent. In 2005, it reached more than 45 percent. While that is an improvement, it is not good enough, and we believe legislation introduced by Energy and Commerce Committee Chairman Dingell is a step in the right direction.

At AmeriChoice, we are pursuing several avenues to educate members about the importance of dental care and to encourage them to obtain it:

- The Happy Smiles program gives members an incentive to encourage them to obtain preventive dental care. Parents who take their children under age 21 for preventive care are given a $10 retailer gift card for every dentist visit.
- We partner regularly with providers, county health departments and Head Start programs to conduct dental screenings of children, provide toothbrushes, and provide basic oral health education, regardless of their insurance coverage. The most recent event, held at Highland Park Elementary Head Start in Landover, Maryland, was attended by 101 children.
- We produce a quarterly bilingual enrollee bulletin which contains periodic articles on dental topics such as "Fluoride for Healthy Teeth" and "Getting Kids to Brush their Teeth"

Effective Partnerships are the Key to Delivering Results

I have spoken of the need for collaboration among all parties involved, including government agencies, schools, community organizations, parents, insurers and the health care community. This collaboration is not just a hypothetical concept. It leads to real benefits in the lives of real people.

In 2006, we launched an ambitious program in Rhode Island to get to the heart of the matter. It is an innovative approach – prevention oriented, focused on early intervention, and engaging both medical and dental providers. In close collaboration with the state, we built a network around caring for children ages 6 and below. We currently have the more than 32,000 Medicaid eligible children in Rhode Island enrolled in the program.

The *RIte Smiles* program stresses preventive care and education, launching these kids on what we hope will be a lifetime of good oral hygiene. All care is provided at no cost to the families of children with Medicaid.

We have eliminated barriers wherever possible, so providers can focus on dentistry. We do only retrospective reviews of claims – no preauthorization is required for most procedures – and we have simplified the credentialing process for providers. We assign case management for special needs and high risk children, and providers are reimbursed for case management when the outcomes are good.

Based on the success of the program, the State is now considering a bill to expand the program to all children up to age 11. It is an excellent example of a public-private partnership providing real value to some of Rhode Island's most vulnerable people, and we are eager to build on what we have learned and start to replicate the program in other states.

I have talked about integrating dental and medical care. A family with Medicaid is much more likely to take a child to see a physician than to see a dentist. Thus, in collaboration with the medical school at Brown University in Providence, we are teaching early detection and rudimentary dental care skills to pediatric medical school students. The students participate in a hands-on course on how to provide a fluoride varnish, which serves as a partial immunization against decay. It is a three-minute procedure, and we compensate providers for doing it. The pediatric students also learn how to detect serious dental problems, so they can make a referral to a dentist in a timely way.

We have other pilot programs that demonstrate the power of collaboration.

- In Paterson, NJ, we are working closely with a school district that has mandated all children visit a dentist prior to returning to school each fall. Enough of these children have Medicaid to drive a good volume of local demand, so we have been able to recruit a robust network of dentists. We also participate in health fairs with pediatricians in the area; and in some cases we work with a mobile dental van that can bring basic care to any location.
- At the Arizona School of Dentistry, we helped fund the establishment of a center for treating special needs children and a mobile treatment program. For AmeriChoice, it is money well spent, because if we can treat patients at home or in a dental facility, they are more likely to avoid a traumatic and expensive emergency room visit.
- In Neptune, NJ, we worked with the University of Medicine and Dentistry of New Jersey to establish a hospital-based dental center, where dental students provide screenings and care to Medicaid-eligible children from 7 p.m. to 10 p.m. every Monday.
- The UnitedHealthcare Children's Foundation (UHCCF) provides financial assistance to help children with medical needs that are not covered by their family's health insurance. UHCCF grants cover the family's share of medical expenses for services which include orthodontia and dental treatments. Since its inception in 1999, the Foundation has provided more than 375 families with nearly $1 million in financial assistance.

These programs work. They provide better outcomes for patients, and in many cases save money in the long run for state Medicaid programs. All that is needed is a willingness to think differently about care, and for the many relevant stakeholders to work in partnership.

Potential Broad Solutions: The Need for a Shared Commitment, Action

Innovative and collaborative partnerships are essential to providing the best options and care for our members. As a starting point, we envision pilot programs where insurers have opportunities to work with government agencies, the community, municipalities, school systems, members and health providers.

- Schools are a valuable mechanism for first dental screenings. As we have experienced in our New Jersey program, initial basic dental care can be introduced through coordinated "dental hygiene days" where dentists examine and provide basic dental care to students at the school.
- Mobile vans can visit large and small communities in remote locations to provide dental care such as exams, x-rays and cleanings. We are exploring rolling out a similar program in Maryland.
- If we want to increase the commitment from dentists to treat Medicaid beneficiaries and, to increase utilization of patients, we need to be able to provide incentives. For instance, as a health insurer, Federal law prohibits us from using Medicaid funds to compensate dentists for missed appointments. Providers have reported "no-shows" as a significant deterrent for accepting Medicaid patients.
- Dental care can be emphasized and elevated as a public health issue through improved partnerships with schools, community centers, private sector, government agencies and houses of worship. Treatment sites can be hosted, full-time or part-time, in alternate venues to provide care and help educate people about the importance of dental care to overall physical health and lifelong well-being.

Policies and Legislation

Medicaid does work. It has been extremely valuable to children and their families across the country. However, Congress can play a pivotal role in improving Medicaid, making it more accessible to providers and easier for the most vulnerable people in our country to use. Currently, states are required to inform Medicaid beneficiaries of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program which provides dentist referrals, regular screenings, and general dental care maintenance and restoration. All 25 million Medicaid beneficiaries under the age of 21 are eligible for EPSDT. However, less than one in four children with Medicaid receive these services. We believe Medicaid could help us as the health plan administrators to increase utilization, so that children and their families receive adequate preventive care for a lifetime of healthy teeth and gums.

We suggest three areas where public policy changes could make the most impact:

- Elimination of separate licensing requirements for Medicaid dentists. Currently in some states, a dentist must obtain a separate Medicaid ID number to participate in a Medicaid HMO.
- Institution of dental screening requirements prior to the beginning of each school year, as is current practice with child immunizations and well-child checkups. Sixty years ago when I was about to enter kindergarten, my parents were required to bring me in for a dental exam. But today, 25 percent of poor children start kindergarten without ever having seen a dentist, and in most cases there is no requirement that they do so.
- Training and education programs to help prepare minority high school and college students for a career in dentistry and grants to train pediatricians and dentists in the field of pediatric dentistry.

In closing, we applaud the efforts of Congress to approach dental care for children more holistically and to consider solutions that help bridge gaps in care. We are committed to working with you, the Senate, providers, and all the participants to address current and future challenges. We are determined to do all we can individually and collaboratively to not only fulfill the promise of Medicaid for children but to help improve on the program.

Thank you, Mr. Chairman for the opportunity to speak today on behalf of AmeriChoice and on behalf of my patients.

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Mr. KUCINICH. I thank the gentleman.
Ms. Tucker.

STATEMENT OF SUSAN TUCKER

Ms. TUCKER. Chairman Kucinich, my name is Susan Tucker. In March 2007, I rejoined the Maryland Department of Health and Mental Hygiene as executive director of the Office of Health Services within the Medicaid program. I am accompanied today by the new Secretary of the Department, John Colmer, who is behind me.

The death of Deamonte Driver is a tragedy. We have been asked to address the oversight mechanisms the Department uses to ensure access to oral health services for Maryland Medicaid's eligible children and to address any measures that we have taken to avoid another tragic loss like that of Deamonte Driver.

Maryland, like all States, has a problem with access to dental services for low-income children. We have been working on increasing access to dental care for years, and, while we have made progress, we recognize that much more needs to be done.

All stakeholders need to help with this issue in Maryland: dental providers, public health programs, parents and caregivers, Medicaid agencies, pediatricians, managed care organizations, and Federal policymakers. This is a national problem.

Only about half of all children in the United States have a regular annual dental checkup. White, non-Hispanic children are almost twice as likely to have usual routine dental checkups as Hispanic or Black children. Children in households where neither parent attended college are much less likely to have an annual dental checkup. Children with Medicaid fall into many of these risk categories. They are more likely to be minority. They are more likely to be poor and to have parents with lower educational levels. This is not an excuse.

This situation is intolerable from a human and public health perspective, but it is a fact. That means that public health agencies providing services for Medicaid populations start from a difficult position.

One of the first priorities of the O'Malley administration in Maryland has been to address dental access issues. We are hiring a State Dental Director and forming a Dental Action Committee, which will include a full array of stakeholders. The stakeholders will be examining the system and social issues which may have contributed to Deamonte's untimely death, and to make recommendations regarding appropriate reimbursement rates for dentists, education to encourage families to improve oral hygiene in the home and to seek preventive dental services in order to assure that children don't get to the point where they are seeking dental care in the emergency rooms, strategies to allow other dental health professionals to provide more preventive services in underserved areas, strategies to increase the training of pediatric dentists—only three pediatric dentists graduate a year from the University of Maryland—and strategies to improve access at federally qualified health centers and school-based health centers.

The Secretary of the Department has requested recommendations by September 2007 and is committed to thoroughly reviewing

these recommendations and implementing changes to improve access to dental services.

In regard to oversight, the Maryland Medicaid program implemented a mandatory managed care program called HealthChoice in 1997. Our main goal at the time was to improve medical and dental care for children. Prior to implementing the program, only about 20 percent of continuously enrolled children received a dental service. Today, 46 percent receive a service.

When we monitor the MCOs we review the dental data on a regular basis to see how many children receive services. We have made improvements. Are we satisfied that we have completed the job? Absolutely not. Are we convinced that we need new efforts and strategies to address the problem? Yes.

We also require MCOs to develop and implement an annual outreach plan. This plan describes outreach activities and includes written materials that MCOs send to encourage families to seek regular care. We review these plans and we do look at the materials that the MCOs do send out to families.

We have addressed rates in this session. DHMH does have low payment rates, but we did increase dental fees substantially in 2001, partly in response to Federal studies, and in 2004 we increased rates again for the restorative procedures. Despite these increases, we recognize that our payment rates are below what dentists receive from private-paying patients. Although fees are not the only answer to increasing dental participation, we know we need to do better.

DHMH also requires MCOs to contract with dentists. In Maryland, as elsewhere, dentists will not contract to take a limitless number of Medicaid patients. If MCOs required contracting dentists to take all Medicaid patients presenting for treatment, most would decline to participate in the program altogether.

We acknowledge that the current approach makes it difficult for patients to find dentists and nearly impossible for the State to monitor ever-changing dental networks. This is unacceptable to us, and we are working with the MCOs to reach out to contracted providers. However, we must also jointly find a way to engage the dental community in Maryland. Dentists in the program need to accept more patients, and dentists not participating need to step up to the plate.

We have met with the Maryland Chapter of the American Dental Association and the Maryland Dental Society, and they have committed to assisting us in this effort.

We also require MCOs to have an infrastructure to assist enrollees with locating and accessing services. They need to be more proactive in assisting patients in receiving dental services.

The Department also has a complaint resolution line, and each member has this information on their card and in their member handbooks. We do receive a lot of calls on this line, but, interestingly enough, we don't receive a lot of dental calls, so families don't call us very often with assistance in this area. We receive about 20 a month. That is not a lot, considering there are 400,000 children on the Maryland Medicaid program.

Finally, Maryland provides modest financial incentives and disincentives to encourage managed care organizations to improve ac-

cess to services. One of the areas that we look at in terms of our pay for performance is dental utilization.

In conclusion, we take our oversight of MCO performance seriously and are committed to implementing additional strategies to increase access to dental services. We ask the committee's assistance in recommending additional Federal dollars for education of pediatric dentists, dental clinics and schools, and federally qualified health centers, and in funding a national dental education campaign to highlight the importance of dental hygiene in the home and regular early preventive dental care.

Thank you.

[The prepared statement of Ms. Tucker follows:]

Susan Tucker
Maryland Department of Health and Mental Hygiene on Access to Dental Care for Children

Domestic Policy Subcommittee
Oversight and Government Reform Committee
Wednesday, May 2, 2007 - 2:00 P.M.
2154 Rayburn HOB

Chairman Kucinich and members of the subcommittee, my name is Susan Tucker. I am the Executive Director of the Office of Health Services within the Maryland Department of Health and Mental Hygiene. I appreciate the opportunity to testify before you today on the progress that we have made in improving access to dental care for children on the Maryland Medicaid Program and on future plans to address dental access issues for low-income Marylanders.

Background and Strategies for Improving Access to Dental Care

We acknowledge that Maryland, like all states, has a problem with access to adequate dental services for all low-income children. It is a problem that we have been working on for many years. While we have made progress in improving dental access for children on Medicaid and SCHIP, much more needs to be done. It is important to understand that this is a long-standing national problem, affecting more than just children on Medicaid and SCHIP. As bad as the national disparities are in access and outcomes in medical care, they are much worse in dental care. We also know that to make progress in improving oral health for children, we need significant efforts on the part of dental providers, public health programs, parents, Medicaid agencies and federal policymakers.

In 2006, the Agency for Healthcare Research and Quality released a report entitled "Children's Dental Care: Periodicity of Checkups and Access to Care, 2003." Highlights of the paper include:

- Only about half of all children between the ages of 2 and 17 have an annual dental check-up, with those between the ages of 2 and 5 are much less likely than older children to have checkups.

- There is a great disparity in access to care by race with white non-Hispanic children (59.5%) being far more likely to have usual, routine dental check-ups than either Hispanic (34%) or black non-Hispanic children (41.7%).
- Children in households where neither parent attended college were much less likely to have an annual dental checkup (33.2% versus 60.9%).
- Tooth decay continues to be the single most prevalent chronic disease among children in the United States, despite the fact that it is highly preventable through early and sustained oral hygiene and regular professional preventive services.

One of the first priorities of the new administration has been to address dental access issues. We are forming a dental action committee which will include a full array of stakeholders. The committee will make recommendations regarding:

- Reimbursement rates for dentists;
- Strategies to engage families in improving oral hygiene in the home and in seeking preventive dental services in order to ensure that children do not get to the point where they are looking for emergency dental services;
- Strategies to encourage the dental provider community to participate in the program;
- Strategies related to dental scope of practice, specifically to allow dental hygienists to provide more preventive services in underserved areas;
- Strategies to encourage the dental school to train more pediatric dentists; and
- Strategies to improve access at Federally Qualified Health Centers and School-Based Health Centers.

Maryland is committed to implementing the committee's recommendations to ensure access to oral health services for all of its Medicaid enrollees through increased availability and accessibility of dentists throughout the state and increased awareness of the benefits of basic oral care among enrollees.

Clearly the United States needs to do a better job addressing this complex health and social issue. At today's hearing, I have been asked to address the oversight mechanisms the Maryland Department of Health and Mental Hygiene uses to ensure access to oral health care for Maryland's Medicaid eligible children. We have also been asked to address any measures that we have taken to avoid another tragic loss like that of Deamonte Driver. Due to federal and state confidentiality restrictions, my testimony here today will focus on programmatic issues relating to the provision of dental care for Maryland Medicaid enrollees.

Oversight of Maryland Medicaid Managed Care Providers

The Maryland Medicaid Program implemented a mandatory managed care program called HealthChoice in 1997. Our main goal under HealthChoice was to improve access to medical and dental care for children. Prior to implementing the program:

Maryland Medicaid dental payment rates for providers were extremely low.

- Only about 20% of children received dental services on an annual basis.
- Few dentists in Maryland participated in Medicaid. Low payment rates were only part of the problem. Dentists had sufficient patients even without caring for any Medicaid patients. In addition, for a variety of social reasons Medicaid patients are much more likely to make appointments and then not show up, leaving the dentist with an empty chair and no reimbursement.

One of Maryland's goals in implementing HealthChoice was to improve access and utilization to dental and other health services for children. We did this through a number of mechanisms. The Department monitors dental data to see whether or not children enrolled in MCOs are receiving dental services. We have seen a steady improvement in this area since moving to managed care. MCOs are required to develop and implement an annual outreach plan, and these plans are reviewed by an External Quality Review Organization. These plans describe outreach activities to encourage families to seek regular dental care.

The Department has increased funding for dental services in past years. We raised rates for most services in 2001 and targeted payment increases to twelve common restorative procedures in 2004. Despite these increases, we recognize that Maryland Medicaid payment rates are below the usual-and- customary payments that dentists receive from private paying patients. They are also lower than the rates paid by many other Medicaid state agencies.

The Department requires MCOs to demonstrate that they have adequate contracts with dentists. Specifically, MCOs are required to have a dentist to enrollee ratio of no higher than 1 per 2,000 for each MCO. As of July 2006, there were approximately 918 dentists enrolled as providers in the HealthChoice program, which is a statewide ratio of 1 dentist to 439 HealthChoice enrollees who are under age 21. This does not include dental services provided through Federally Qualified Health Centers or local health departments. Even though the statewide ratio of dentists to HealthChoice enrollees meets the regulation requirements, many dentists only accept a certain number of patients. As a result, Medicaid recipients often have problems finding dentists.

Mandates also exist to ensure that each of the MCOs has the appropriate infrastructure to assist enrollees with locating and accessing services. For instance, each MCO must operate a consumer services hotline to assist its enrollees with information about how to use and access the MCO and its provider networks, including locating a dentist. In conjunction with this effort, the Department operates a HealthChoice Enrollee Action Line and the HealthChoice Provider Hotline. The hotlines assist members with managed care problems and intercede on their behalf when they are having problems accessing services. These numbers are on the back of every Medicaid enrollee's membership cards.

Finally, Maryland provides both incentives and disincentives to encourage the managed care organizations to improve access to services. A key focus for the Department has been to work with the MCOs to improve dental services for children between the ages of 4 and 20.

Conclusion

As a result of many of these measures, utilization for dental services for children with Medical Assistance coverage has increased from 19.9% to 45.8 %. We take our oversight of MCO performance seriously and while pleased with this progress, the Department is committed to implementing additional strategies to increase access to dental services.

Mr. KUCINICH. Thank you very much, Ms. Tucker.

Ms. Perkins, you may proceed. Thank you.

STATEMENT OF JANE PERKINS

Ms. PERKINS. Thank you. Thank you for having me here this evening.

I wanted to, in my few moments, just go through again some issues that are present in the States and talk about a few more issues with respect to this Centers for Medicare and Medicaid Services.

To flip the statistics that have been used today, in 2004 70 percent of kids who were eligible didn't get any dental care, 80 percent of kids who were eligible didn't get any preventive care, and over 85 percent of kids who are eligible didn't get corrective treatment.

It is true that the Driver's stories are not unique to Maryland. In the District of Columbia, children enroll in one of four managed care organizations. The Medicaid Act requires States or MCOs, managed care organizations, to assure CMS and the States that they maintain a sufficient number, mix, and distribution of providers; however, the participation list in the District had been repeatedly inaccurate, listing dentists as participating when they no longer do, when they have closed offices. Some have moved overseas.

According to the D.C. Action for Children, 5 percent of licensed dentists in the District participate in Medicaid, and by saying participate there, that means taking even one claim. That doesn't talk about active participation.

The court monitor, in an ongoing case in the District, found "substantial evidence that the majority of children eligible are not receiving adequate dental care."

According to the District's 416 report, which we just received for 2006, 22 percent received a preventive dental service, and that was less than had received preventive dental care in 2005.

Mr. KUCINICH. Excuse me? What was that percentage?

Ms. PERKINS. It was 22 percent in 2006 versus 25 percent in 2005. Only one of the four participating managed care organizations increased their percentages. The others, Health Right, Charter, and AmeriGroup, showed decreases.

In Miami-Dade County, a pilot project that was proposed by Governor Jeb Bush and approved by CMS in record time requires children to enroll in a capitated managed care plan. A report from the State's contractor found that the number of children who received dental care through the program dropped 40 percent in the first year. The number of participating dentists declined from 669 to 251. An analysis by Columbia University found that the State lost value under the program by paying the same amount for less care and less quality.

To give an example, a dental group which was paid $4.25 a month for each of 790 children provided services to 45 of them. That is 5.7 percent during the first 6 months of 2005. Thus, the group was paid $20,145 for treating 45 children.

A handful of Medicaid programs in States such as Alabama, Indiana, South Carolina, Vermont, and Virginia have targeted children's oral health services. These efforts share some common fea-

tures: first, increases in payment levels tied to usual and customary fees; second, streamlined administration; third, appointment of a high-level position to focus on problem solving; fourth, effective outreach to beneficiaries; and, fifth, case management to address appointment no-shows.

South Carolina's effort to tie patient navigators with beneficiaries has resulted in 85 percent of beneficiaries keeping their appointments. I would point out that case management is a covered Medicaid service. Athens County, OH, and Oakland, CA, are a couple of other examples of areas that have used case management to make sure kids get to their appointments.

To use an example from Virginia, until recently, as Mr. Smith pointed out, Virginia has delivered services using a capitated managed care mode; however, the State recently transitioned out of that model and back to fee for service. This move, coupled with additional changes, a 30 percent increase in rates and a number of recruitment and retention strategies for dentists resulted in 76 additional dentists enrolling in the program between July and November 2006, and there was a 43 percent increase in preventive services and a 75 percent increase in restorative services delivered to Medicaid eligible children between 2005 and 2006.

Many of the points that I wanted to make or was going to make about CMS have been covered here already. I will just add three points.

First, the Medicaid Act requires that the Secretary of Health and Human Services shall annually develop and set participation goals for EPSDT for each State. Given the increased use of managed care and the stated rule of managed care to provide children a medical and dental home, it could be expected that the Secretary would increase these participation goals over time. However, the last time the Secretary developed and set participation goals was 1990.

Second, CMS appears committed to privatizing monitoring by allowing States and MCOs to use performance measures that are tied to those or offered by private accreditation standards. However, the private standards lack the degree of specificity needed to assure that States are complying with the Medicaid Act. For example, 2007 HEDIS includes only one dental measure, annual dental visit. By contrast, 416 requires States to report on the number of eligible children receiving services, the number receiving preventive services, and the number receiving corrective treatment.

Moreover, the HEDIS is not measuring what Congress has required in the statute for the States to do, and that is to ensure dental visits according to schedules arrived at by the State after consultation with dental providers. Our review found that, as of May 2005, all but three States called for children to receive a dental exam every 6 months, not annually.

Third, CMS has not enforced the Medicaid Act, so it is important that beneficiaries' rights to enforce the provisions of the act be reaffirmed by Congress.

Thank you for having me here today.

[The prepared statement of Mr. Perkins follows:]

Testimony of Jane Perkins, JD, MPH
Legal Director, National Health Law Program
Los Angeles, CA-Washington, DC-Chapel Hill, NC

May 2, 2007
US House of Representatives
Committee on Oversight and Government Reform
Subcommittee on Domestic Policy

Hearing on Oversight of Dental Programs for Medicaid-Eligible Children

Good afternoon. My name is Jane Perkins. I am the Legal Director of the National Health Law Program, an organization working at the local, state and national levels on behalf of working poor and low-income people. I have been at the National Health Law Program for over 22 years, focusing on children's health and public insurance, particularly Medicaid.

My testimony today addresses the performance of states in assuring that children obtain dental services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program—a mandatory benefit for children and youth under age 21. I will also discuss the role of managed care organizations (MCOs) in the provision of EPSDT dental services and oversight by the Centers for Medicare & Medicaid Services (CMS) in assuring that states operate their programs in compliance with the Medicaid Act and implementing rules.

States' performance. The Subcommittee has heard the story of Deamonte Driver. The problems highlighted by his story are not unique to Maryland.

Congress requires states to report to CMS annually on the number of children receiving dental services.[1] States are to use a uniform reporting form, called the CMS-416, to collect and report the data. In the states reporting in FY 2004 (seven states are missing), only 30 percent of children received any dental services, and only 22 percent had a preventive visit. Even fewer children, 16 percent, received any dental treatment services. There was significant variation according to the child's age and the state where the child lived.[2] *Please note*: Although CMS has released CMS-416 data for FY 2005, it was not used for this testimony because 15 states' reports are missing. Examples from individual states help explain the national data:

- In California, our office serves as the lead agency for the Health Consumer Alliance (HCA), a partnership of independent consumer assistance programs in thirteen counties that are home to over three-fifths of California's low-income residents. Together with the Health Rights Hotline in Sacramento, HCA responds to approximately 1,400 requests for assistance each month. Since its inception nine years ago, access to dental care has remained among the top five service problems for which beneficiaries seek assistance from HCA. A 2002 study found that denial of essential dental services was the number one problem for

beneficiaries who called about dental issues (32 percent of the services problems). Other frequent problems involved delays in obtaining authorization from the State or MCO for dental services, difficulties obtaining specialized treatment, quality of care, language barriers, and misunderstandings among providers and MCOs about what dental services EPSDT covers (e.g. medically necessary orthodontia to address handicapping malocclusions—for example, a nine-year-old who needed orthodontia to address a significant overbite which caused her lower incisors to cut into the soft tissue of her upper palate).[3] California's dental utilization rates, as reported on the CMS-416, are among the lowest in the country.

- According to a June 2003 report from the Court Monitor in the ongoing *Salazar v. District of Columbia* case, "substantial evidence indicates that the majority of eligible children in the District's EPSDT program are not receiving adequate dental care."[4] The Medicaid Act requires each Medicaid-participating MCO to assure CMS and the State that it maintains a sufficient number, mix and distribution of providers.[5] However, there have been problems verifying the extent of dentists' participation in the District's program. In March 2005, the District provided a list of participating dentists to the *Salazar* legal counsel. Counsel surveyed dentists on the list. Of the 135 unduplicated dental providers named, only 45 individual dentists and one clinic confirmed that they accepted Medicaid-eligible children. Of the 45 dentists, 29 were general dentists; six, oral surgeons; three, pediatric dentists; and one, an orthodontist (with the remaining 6 dentists unidentified by specialty). The other 89 dentists or dental offices were no longer serving Medicaid clients, had moved, had closed, or numerous attempts to make contact were unsuccessful. In March 2006, the District submitted an updated list. By counting each name only once (a number of dentists were enrolled in more than one MCO and in fee-for-service), a total of 63 dentists, nine oral surgeons, and one orthodontist were available to treat all EPSDT eligible children in the District (over 90,000 children). Notably, these data say nothing about the extent of dentists' participation, for example whether the dentist is accepting new Medicaid patients or limiting the number of children served.

- In Miami-Dade County, a pilot project proposed by Governor Bush and approved by CMS in record time has enrolled Medicaid children in a dental home and pays a per member per month amount for each child. A report from the State's contractor, the University of Florida Institute for Child Health Policy, found that the number of children who received dental care through the Medicaid program dropped 40 percent during the first year. Only 22 percent of eligible children visited a dentist, compared with 37 percent under the old fee-for-service system. The number of participating dentists declined from 669 to 251. Other reports showed a dental group, which was paid $4.25 a month for each of 790 children, provided services to only 45 (5.7 percent) during the first six months of 2005. Thus, the group was paid $20,145 for treating 45 children.[6] An analysis from the College of Dental Medicine at Columbia University found that costs under the program stayed about the same and that the State of Florida lost value by paying the same amount for less care and less quality.[7]

A handful of Medicaid programs have targeted children's oral health services and increased utilization. These efforts, in states such Alabama, Georgia, Indiana, South Carolina, Texas, Vermont, and Washington, share some common features: First, adequate payment levels tied to dentists' usual and customary charges and commercial products in the state; second, administrative changes that streamline the program; third, appointment of a high level committee or departmental position to focus on problem solving; fourth, effective outreach and marketing to beneficiaries; and fifth, case management to address appointment no-shows. For example:

- Alabama reported a 68 percent increase in children's utilization of dental services between FY 2001 and FY 2005 after it launched *Smile Alabama!*, an initiative that included a public awareness campaign, dedicated personnel to assist dental providers with administrative issues, recruitment efforts led by the governor, and a payment increase in 2000 to match BlueCross/BlueShield of Alabama rates.

- In South Carolina, shortages of dentists resulted in few providers being available to care for Medicaid-enrolled children. South Carolina developed an initiative to train general dentists to expand their practices to treat pediatric and special needs children. Payment rates were increased to the 75th percentile of rates in the region, resulting in a 73 percent increase in the number of participating providers. The State also addressed recipient outreach. One campaign partnered with the African Methodist Episcopal Church to offer dental screening at more than 110 events. Patient navigators were used to assist families in scheduling appointments, and more than 85 percent of those families kept their follow-up appointments.

- Virginia recently transitioned its delivery of dental services out of capitated managed care and back to the fee-for-service system. This move, coupled with additional changes (e.g. a 30 percent increase in dental rates and dentist recruitment and retention strategies), resulted in 76 additional dentists enrolling in the program between July and November 2006. There was a 43 percent increase in preventive services and a 75 percent increase in restorative services delivered to Medicaid-eligible children between SFYs 2005 and 2006.[8]

CMS' efforts at oversight. CMS has known for at least 15 years that Medicaid-enrolled children are not receiving the dental care that they are entitled to through EPSDT. CMS has been repeatedly told that there needs to be increased review and monitoring, particularly in states contracting with MCOs.

In August 1992, the Office of Inspector General (OIG) recommended that, "The HCFA [now CMS] should enhance monitoring procedures to assure the accuracy of states' reporting," a recommendation with which HCFA concurred.[9] Five years later, the OIG noted the failure of managed care plans to cover mandatory EPSDT services and again called for "increased review and monitoring by HCFA, especially among States with mandatory managed care enrollment."[10] On January 18, 2001, the federal agency, citing a Government Accountability Office (GAO) study, notified State Medicaid

Directors that overall utilization of dental care by EPSDT-eligible children remains low. The agency told states of its intent to increase oversight and informed them that "it is especially important to assure that dental utilization data are obtained by the State from the managed care organizations."[11] If children's dental visits fell below 50 percent of eligible children, the state was to submit a plan of action for improving access. At least 45 states and the District of Columbia submitted plans. Although the January 2001 letter made suggestions to states for improving utilization and informed states that CMS would be conducting investigations, there does not appear to have been significant follow up.

The OIG, GAO and HCFA have all also noted the importance of accurate reporting on the CMS-416. This form provides valuable information about each state's EPSDT performance, annually and over time. It also provides information to CMS about whether the mandates of the statute are being met. CMS revised the reporting form in 1999 and, among other things, improved the required reporting for dental services. However, there does not appear to have been any significant follow up by CMS when states submit forms showing that children's utilization of services is low. For example, looking back over the last seven years, our office has not located any Notices published by the federal agency in the *Federal Register* that refer to enforcement actions using the CMS-416 or that announce that a state Medicaid program was being sanctioned for failing to provide dental services to needy children.

Notably, the Medicaid Act provides that the Secretary of the Department of Health and Human Services shall annually develop and set participation EPSDT goals for each state.[12] Given the increased use of managed care and the stated role of managed care to provide children a "medical and dental home," it could be expected that the Secretary would annually increase the participation goals for each state. However, the last time the Secretary developed and set annual participation goals was in 1990, when the goals called for each state to provide at least 80 percent of EPSDT recipients with timely medical screening by FY 1995.

When it revised the CMS-416 form in 1999, CMS issued detailed instructions to the states for completing the form. Nevertheless, we have heard complaints from some states and managed care organizations that the completed forms under-report the number of children receiving EPSDT services. When studies have occurred, however, they have usually confirmed the accuracy of the 416s.[13] The CMS-416, like all other uniform Medicaid reporting forms completed by states and submitted to CMS, represents each state's presentation of its activities, and as such, serves as an important indicator of state performance.

CMS has taken steps to provide information to states. The *Guide to Children's Dental Care in Medicaid* (Oct. 2004) includes information about how to organize and manage oral health care for children under Medicaid's EPSDT service. However, CMS says the guide is not intended to change current Medicaid policies nor impose any new requirements. Through the use of *Dear Medicaid Director* letters, CMS could address issues that we see regularly in our state-based work. For example, child advocates from Massachusetts have noted the need for clear federal direction that EPSDT covers case

management and transportation services to help avoid broken dental appointments. The provision of dental services in schools (the places where kids are) could be enhanced by clear federal direction supporting comprehensive dental care in schools and explaining how states can use Medicaid funding to pay for it. Child advocates in Missouri point out the need for CMS to issue and enforce guidance to assure adequacy of dental networks, stating that it is not uncommon for some families, especially in rural areas, to travel up to 200 miles to obtain dental care through their MCO. The provision of dental services is also affected by multiple contracting and subcontracting arrangements resulting in multiple layers of administrative costs being taken from the per member per month payment without assuring adequate pass through of funding to the dental care provider. Investigation of this problem by CMS could be beneficial.

CMS appears committed to privatizing quality monitoring by allowing states and MCOs to use private accreditation standards to measure performance. Standing alone, this is problematic. The private measures lack the degree of specificity required by the CMS-416. For example, the 2007 HEDIS includes only one dental measure—annual dental visit. By contrast, the CMS-416 requires states to report on eligible children receiving preventive, treatment and any dental services according to five age groupings. Moreover, by measuring only annual dental visits, the HEDIS is not measuring what Congress has required in the statute: dental visits according to schedules arrived at by the state after consultation with dental providers. Our review found that, as of May 2005, all but three states call for children to receive a dental exam every six months, not annually.[14]

CMS has recognized problems with the low dental provider participation and payment rates. However, CMS does not appear to have exercised its enforcement and oversight authority to require individual states to address these problems. Moreover, it introduced confusion about which laws apply to MCOs. Before 2002, the agency consistently said the "equal access' requirement, 42 U.S.C. § 1396a(a)(30)(A), applies to MCOs and requires state Medicaid payments to ensure that covered services are available to Medicaid recipients at least to the extent the services are available to the general population. Indeed, the Medicaid Act does not exclude MCOs from compliance with (30)(A). However, statements by CMS in June 2002 confused the point, hinting that the access requirement may apply only in fee-for-service settings.[15]

In conclusion, we appreciate the opportunity to report to you today. Children's dental care remains a neglected stepchild among health policy priorities. Unfortunately, poor dental health can cause pain and infection, contribute to poor digestion and diet, affect a child's speech and appearance, and can cause other serious health problems, including heart attacks, strokes and, in Deamonte Driver's case, death.

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[1] *See* 42 U.S.C. § 1396a(a)(43)(D) (West Supp. 2006).

[2] *See* CMS, *Annual EPSDT Participation Report Form CMS-416s* (Fiscal Year 2004), http://www.cms.gov; National Health Law Program, *Children's Health under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment 1999-2003* at 17-21 (May 2005).

[3] *See* Health Consumer Alliance and Health Rights Hotline, *Denti-Cal Denied: Consumers' Experiences Accessing Dental Services in California's Medi-Cal Program* (Dec. 2002).
[4] *See* Henry T. Ireys, PhD, Court Monitor, Salazar v. District of Columbia, Civil Action No., 93-452(GK), *Methods Used by the District of Columbia and the Managed Care Organizations to Inform Recipients about Preventive Dental Services* (June 17, 2003) (citing the District's quarterly reports that only about 15 percent of eligible children received a dental assessment). The National Health Law Program serves as co-counsel for the children in this case.
[5] *See* 42 U.S.C. § 1396u-2(b)(5)(B), *see also* § 1396u-2(a)(5)(B) (requiring MCOs to provide, upon request, information showing identity, locations, qualifications, and availability of participating providers).
[6] *See* John Dorschner, *A new study reports that a pilot project in Miami-Dade to privatize the dental care of poor children resulted in a huge drop in treatment,* Miami Herald (Jul. 30, 2006); *see* Elizabeth Shenkman, PhD, Institute for Child Health Policy University of Florida, *Evaluation of the Miami-Dade County Prepaid Dental Health Plan Year 1 Baseline Report* (June 27, 2006).
[7] Burton L. Edelstein, DDS, MPH, Professor of Dentistry and Health Policy & Management, Columbia University, *Miami-Dade County Prepaid Dental Heath Plan Demonstration: Less Value for State Dollars* 3 (Aug. 2006).
[8] *See* Smiles for Children, Presentation to Dental Advisory Committee, *A New Day for Oral Health in Virginia* (Jan. 5, 2007) (emphasis is original).
[9] *See* Office of Inspector General, U.S. Dep't of Heath and Human Services, *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)—Performance Measurement* 9 (Aug. 1992).
[10] Office of Inspector General, U.S. Dep't of Heath and Human Services, *Medicaid Managed Care and EPSDT* (May 1997).
[11] Health Care Financing Administration, US Dep't of Health & Human Services, *Dear State Medicaid Director* (Jan. 18, 2001).
[12] *See* 42 U.S.C. § 1396a(a)(43)(D) (West Supp. 2006).
[13] *See, e.g.,* National Health Law Program, *Toward a Healthy Future—Early and Periodic Screening, Diagnosis and Treatment for Poor Children and Youth* at 44 & n.275 (Apr. 2003) (collecting studies).
[14] *See* National Health Law Program, *50-State Dental Periodicity Schedules* (May 2005), http://www.healthlaw.org.
[15] *See* 67 Fed. Reg. 40989, 41036 (June 14, 2002).

Mr. KUCINICH. I want to thank all the witnesses for their testimony.

At this point we will go to questions.

I want to thank Congressman Cummings for rejoining us.

I would like to begin the questions with Dr. Finklestein.

Doctor, in 2006 how many children eligible for Medicaid in Maryland enrolled in your plan?

Dr. FINKLESTEIN. Out of total membership of 110,000, approximately 80 percent of those are children.

Mr. KUCINICH. That was 110,000 that were what, please?

Dr. FINKLESTEIN. It is 110,000 total membership, of which 80 percent are children.

Mr. KUCINICH. OK. The Department paid, according to the information we had, the Department paid United Health Care $339.3 million in 2006. How much in total revenue did you receive from the State of Maryland Medicaid program for enrolling these children during 2006?

Dr. FINKLESTEIN. Sir, I don't have those numbers. I would be happy to share them with the committee to make sure they are accurate.

Mr. KUCINICH. Thank you, sir.

And in 2006 do you know how many of the Maryland Medicaid children enrolled in your plan received at least one preventive dental service?

Dr. FINKLESTEIN. Yes, sir. Over 45 percent.

Mr. KUCINICH. So 45 percent. OK.

Dr. FINKLESTEIN. And if I can followup?

Mr. KUCINICH. Of course.

Dr. FINKLESTEIN. Again, I am a dentist. That is 55 percent of my children that didn't receive. That is unacceptable, totally unacceptable. Until we get 100 percent, then we are talking about the numbers that I can do the proper health care for my children.

Mr. KUCINICH. Thank you, Doctor. And how many received at least one dental treatment service during the year?

Dr. FINKLESTEIN. At least one?

Mr. KUCINICH. You said 45 percent received at least one preventive dental service, but how many have received at least one dental treatment service during the year?

Dr. FINKLESTEIN. I could make that available to the committee.

Mr. KUCINICH. Could you do that, please?

Dr. FINKLESTEIN. Sure.

Mr. KUCINICH. Now, Doctor, did Deamonte Driver see a dentist in the year before he was hospitalized?

Dr. FINKLESTEIN. Sir, in all my years of treating patients, there has always been a certain trust. Discussing this individual case would be a total violation of that.

Mr. KUCINICH. Have you been advised by counsel not to discuss it?

Dr. FINKLESTEIN. This is the person sitting in front of you.

Mr. KUCINICH. This committee, you should be informed, Doctor, has oversight jurisdiction specifically and actually a specific exemption from HIPAA with respect to gathering information and data, so we are going to ask you, if you cannot do it now, to provide for the committee the following information.

Staff has just given me something, and I would like to read this to you. This is section 45, and it is 35th chapter, No. 164.512(d)(1) states that "A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including—" subparagraph 2—"Government benefit programs for which health information is relevant to beneficiary eligibility."

The Committee on Oversight and Government Reform is the principal oversight committee in the House of Representatives with broad investigative jurisdiction as set forth in House Rule 10, so information—and I just want to make sure that you, as a witness, have that information. So what I am going to say, if you are not prepared to answer that question at this moment—and I will respect that you aren't available to answer that question at this moment—we are going to ask you to submit to this committee the following information: Whether or not Deamonte Driver saw a dentist in the year before he was hospitalized; whether he saw a dentist in the year before that or the year before that, the previous year. We could actually go back 5 years, at least.

And I would ask you to provide the following information, as well: if United Health Care received a capitation fee for Deamonte Driver in the year before he was hospitalized and in the 5-years preceding that.

Would you be able to answer that now? If you can answer some of these questions now, that would be helpful, but if you want time to do it and you want to prepare a response——

Dr. FINKLESTEIN. I would appreciate that.

Mr. KUCINICH. You would like to have time to do it?

Dr. FINKLESTEIN. Yes, sir.

Mr. KUCINICH. I respect that, Doctor.

I would like to ask you, Doctor, what statistic does United Health Care generate about its own performance that would capture Deamonte's last 5 years of life? For example, do you report a statistic to the State about the number of enrollees who do not receive dental services in the preceding year?

Dr. FINKLESTEIN. Sir, if I can talk globally?

Mr. KUCINICH. Of course.

Dr. FINKLESTEIN. If that is OK with you, we have a tracking system throughout the country. It is called universal tracking. This is a report card on all of our children that are EPSDT. The T is the key. I totally agree with that.

In that report card, it is sent on to the primary care physician. Primary care physicians get a report on the child for not only baseline examination, physical examination—this is the pediatrician—they get lead screening, well child, immunization, and dental. Those are sent to the physicians so that they know exactly which children fall in or fall out.

In addition to that, as a company we do total outreach to our members that have not seen their dentist. That includes phone calls, it includes mailings, it includes educational material on a quarterly basis that is sent, and there is a 24-hour call center that is available to all of our members. Not only that, they are trained to educate members. They also help to navigate them through the system. Again, transportation to and from, and even scheduling

them so that they can be rewarded with a gift certificate when they do go to the dentist.

Mr. KUCINICH. OK. What I would like you to do, Doctor, I am going to ask you this information and I would urge you to consult with your attorneys so that you could make sure that you feel comfortable reporting this, and I can assure you that if any information is necessarily privileged for some legal reason, such as a pending lawsuit or anything like that, our staff attorneys will be glad to acquaint you with the way in which this committee handles such information.

So we are going to want you to provide us with a report whether or not you keep statistics about the number of enrollees who do not receive dental services, if you report those statistics to the State, what the report. We would like you to have that available for at least the last 5 years, assuming, of course, that it is possible to generate such statistics. I mean, if you have them, the committee would like to take a look at them.

I assume that you do keep statistics?

Dr. FINKLESTEIN. Yes, we do, sir.

Mr. KUCINICH. So it is possible——

Dr. FINKLESTEIN. Absolutely.

Mr. KUCINICH [continuing]. To determine utilization?

Dr. FINKLESTEIN. Absolutely.

Mr. KUCINICH. OK. So we want to be able to determine, of course, whether or not you are informing the State about the existence of individuals who are chronically not receiving dental care. I think you would have to agree that would be relevant for the State to know.

I would now like to ask you, Doctor, United Health Care uses HEDIS measures to estimate how many children are eligible for Medicaid, correct?

Dr. FINKLESTEIN. HEDIS? Yes.

Mr. KUCINICH. Yes. Now, according to HEDIS, eligible children are 4 to 20 years old and enrolled in Medicaid for 320 consecutive days. In 2006, according to information that this committee has been given, Deamonte was not enrolled for 63 days. Is that correct according to your information?

Dr. FINKLESTEIN. I would have to confirm that.

Mr. KUCINICH. OK. If anyone is not enrolled for that length of time, would that person be ineligible according to HEDIS standards?

Dr. FINKLESTEIN. Would they be for reporting purposes?

Mr. KUCINICH. Yes. I will go over it again.

Dr. FINKLESTEIN. No, I understand the question.

Mr. KUCINICH. If they weren't enrolled for, let's say, 60-some days, would that person then be ineligible according to HEDIS standards?

Dr. FINKLESTEIN. No. They wouldn't be a required reporting statistic.

Mr. KUCINICH. Excuse me?

Dr. FINKLESTEIN. They would fall out of reporting only. Again, we are treating children, if they are enrolled with our plan for 1 month or for an entire year. HEDIS says our denominator consists of only children that are continuously enrolled for 320 days. That

is only a reporting statistic. This does not interfere with their dental coverage. Whoever the patient is would have dental coverage for as long as they are enrolled in our plan.

Mr. KUCINICH. We are trying to establish whether or not Deamonte, based on the circumstances, would have been part of the eligible children that you list. Would he have been considered eligible?

Dr. FINKLESTEIN. Any child in our health plan is eligible for care. What we are doing——

Mr. KUCINICH. You are eligible for care, but are they reported as such?

Dr. FINKLESTEIN. They are not required to be reported under the definition of HEDIS.

Mr. KUCINICH. So someone could be eligible but they could fall out of reporting?

Dr. FINKLESTEIN. That is correct, sir.

Mr. KUCINICH. Now, what kind of a bearing does that have on United Health Care's responsibility for making sure that a patient gets access to health care, which includes dental?

Dr. FINKLESTEIN. None, whatsoever.

Mr. KUCINICH. In other words, whether someone is reported or not, it has no bearing on the service, but it does have a bearing on whether or not the State can determine utilization, right?

Dr. FINKLESTEIN. If I may expound, HEDIS is a pure measure of one time dental treatment, I can tell this committee. Do I find quality in that? There is no quality component to it. It is strictly——

Mr. KUCINICH. No quality component?

Dr. FINKLESTEIN. There is no quality component at all.

Mr. KUCINICH. To what?

Dr. FINKLESTEIN. To the HEDIS measure. OK? I am talking now——

Mr. KUCINICH. It is strictly eligibility?

Dr. FINKLESTEIN. It is strictly a way to show utilization. It was so pointed out by Mr. Davis when he spoke about treatment. When I go into the OR with a child who has been devastated, totally devastated by milk bottle decay——

Mr. KUCINICH. By what?

Dr. FINKLESTEIN. Milk bottle decay, which means that the child has been going to sleep at night, and the only way to bring this child back to oral health is in the operating room. That is the same HEDIS count as if the child came to my office and I did a quick screening. It is a one-time hit. If that is quality, not in my dental life.

Mr. KUCINICH. Now, I think we mentioned this earlier. The State of Maryland paid United Health $339.3 million in 2006. Those are the figures that we had. In Deamonte's case, in particular, you were paid about $80.96 a month. Does Deamonte appear in your annual records?

Dr. FINKLESTEIN. Again, sir, I will talk globally about my members. Any member will appear in our records. OK? It has nothing to do with HEDIS. From the day they are in, if they are brought into a dental office—you have one of our top doctors was here before testifying. He has one of the highest utilizations at the Univer-

sity of Maryland with quality outcomes. That was available. Care was available. The only way I can treat a child—I said that in my statement—is by having them in my dental chair. The same thing with Dr. Tinanoff and Dr. Clark.

Mr. KUCINICH. I accept what you are saying, except that if you could tell me how do the numbers account for failure to provide care in Deamonte's or in anybody's case?

Dr. FINKLESTEIN. In anybody's case?

Mr. KUCINICH. Yes.

Dr. FINKLESTEIN. It is absolutely. I don't know if we can say the word failure, but it is.

Mr. KUCINICH. What is a failure?

Dr. FINKLESTEIN. A failure is not having 100 percent of our children in this country seeing the dentist. A failure is not having the ability to mandate that my children go to the dentist. A failure is having school systems that won't let me in to do screening because they take away from chair time, education time.

Mr. KUCINICH. Doctor, would the failure also be if the numbers weren't kept to account?

Dr. FINKLESTEIN. No. No, sir. I pride myself and this company prides itself on individual care, on outcomes. That is what it is about. Numbers are wonderful——

Mr. KUCINICH. But the numbers have to be reported so there can be some kind of assessment of utilization; am I correct?

Dr. FINKLESTEIN. That is so true.

Mr. KUCINICH. OK. And so would the numbers that are reported to be able to assess utilization in any way reflect the failure? You just said, 55 percent aren't cared for. Is that one way of looking at it?

Dr. FINKLESTEIN. That is exactly right. Not only that. The way I assess it, we have a system called Metrix, and Metrix looks at what each individual child is getting when they do access care, not that it is a one-time exam. What we do is measure on their recall, when they come back 6 months, do I have baseline health. That is what it is all about. Getting the child in, getting them healthy, maintaining health, not 5 years prior, but every day of their life, that is my commitment to you.

Mr. KUCINICH. Doctor, what in your records or figures of United Health Care reflects the death of Deamonte?

Dr. FINKLESTEIN. Again, sir, I have never violated this in my life. If you want, I will present you with anything——

Mr. KUCINICH. I don't want to ask you to do anything the you are really uncomfortable with, but I do want to say that this committee needs the following information.

Dr. FINKLESTEIN. OK, sir.

Mr. KUCINICH. We want to know specifically where did Deamonte appear in your annual records. We want to know the manner in which your statistical evaluation and your numbers account for any failure to provide him with care. We want to know what in your records or figures reflects the death of Deamonte. And, again, this is consistent with the right to information which this committee has, and specifically under rule 8(a)(1) of the Rules of the Committee on Oversight and Government Reform.

Doctor, again, thank you. We verbally requested documents reflecting United Health Care's costs, their earnings, and revenues from the Department of Health and Mental Hygiene. That Department refused. We made the verbal request a second time. We submitted a document request to the Department of Health and Mental Hygiene that included a request for United Health Care's costs, earnings, and revenues. We were told by the Department that United Health Care refused to release that information because it was described as proprietary.

Again, I know that you are a doctor, you are not an attorney, I understand, but I want you to know that we insisted that our subcommittee had the right to that information under rule 8(a)(1) of the Rules of the Committee on Oversight and Government Reform. The Department responded that United Health Care did not grant express consent to release that information and therefore refused our request a second time.

We are entering a written request as well as refusals to produce the requested documents in writing into the record. Without objection, Mr. Cummings, this goes in.

Now, Doctor, half of United Health Care's funding is Federal, and we have an obligation and responsibility to make sure that funding is spent appropriately. This is exactly why this subcommittee has broad jurisdiction and investigative jurisdiction as set forth in House Rule 10. Now, would you be at liberty at this moment to tell us what United Health Care's costs, earnings, and revenues were in Maryland?

Dr. FINKLESTEIN. No, I do not have that information.

Mr. KUCINICH. OK. So our subcommittee is formally making that request right now for you to provide the cost, earnings, and revenues in Maryland.

Now, my understanding is that the National Children's Medical Center incurred expenses in excess of $200,000 in providing emergency care and treatment to Deamonte in the last few weeks of his life. He was uninsured at the time of admission into the hospital. He leaves no estate. His family is unable to afford the charges. I am assuming that the Maryland Medicaid program will not be paying the charges and that the United Health managed care plan with which Maryland Medicaid contracted to manage Deamonte's care also will not pay. Do you have any advice for the National Children's Medical Center as to where they might turn to recoup even some of the costs they incurred in attempting to save his life?

Dr. FINKLESTEIN. At this time, again, I can't comment on the individual nature. I don't even have this material in front of me, sir.

Mr. KUCINICH. OK. Doctor, one measures of how much value a public program like Medicaid gets from purchasing care through a managed care organization like United Health, as you understand, is the medical care ratio. This is the amount that the MCO pays out for medical cost divided by the amount of premium revenues that the MCO takes in. Are you familiar with the medical care ratio, Doctor?

Dr. FINKLESTEIN. I know exactly what you are talking about. I just happen to call it benefit.

Mr. KUCINICH. You call it benefit?

Dr. FINKLESTEIN. I call it benefit, not medical. There is more to it than just——

Mr. KUCINICH. So the higher the ratio or the benefit, the better the value for Medicaid. And for example, if an MCO's medical cost ratio on a Medicaid managed care contract is 60 percent, then only $3 out of every $5 the State and Federal Government pay the MCO goes to purchase hospital, physician, dental, and other health care services. The remaining $2 goes to administration, marketing, and, in the case of a for-profit company like United Health, profits.

So if the medical cost ratio is 90 percent, then $9 out of every $10 the State and Federal Government pay the MCO goes to purchase health care services and only $1 goes for administration, marketing, and profits.

Now, according to form 10K that United Health filed with the Securities and Exchange Commission on March 6, 2007, their company's overall medical care ratio in 2006 was 81.2 percent. In other words, a little under $1 out of every $5 you get paid in premium goes to marketing and administration and profits.

Now, would you be able to tell us what the medical care ratio was on your risk contract with the Maryland Medicaid program in 2006? Would you be able to tell us that?

Dr. FINKLESTEIN. No, I don't have that.

Mr. KUCINICH. If you could please——

Dr. FINKLESTEIN. May I just put in you still have a claims run. It would be an approximation.

Mr. KUCINICH. If you could provide us with the information, understanding that there is a claims run, we would like to get that.

I think that is the only questions I have right now before we go to Mr. Cummings.

I just want to say, Doctor, I admire the spirit in which you presented your concern for the children who you are dedicated to serving. You speak of them as your children, and I think it is heartening to see the concern that you expressed for the children. I think you understand that our committee has the same motivation in asking for the information which we feel we need to be able to effectively evaluate this case and to, from a public health policy standpoint, to be able to use the information we gather not simply as an analysis of United Health Care, but to look at it from the more global experience of the industry, itself.

So I think it would be good if we were able to proceed on this in a cooperative way, because I think that it can be a very favorable experience for everyone who is involved in committing themselves in the care of children.

Dr. FINKLESTEIN. Thank you. I appreciate those kind words. The frustration that is inside of me, I can't even tell you. This is not the first case. I hope and pray it is the last case. Any skilled dentist could have brought health to any one of these children, whether it was Mississippi this month, New York 3 years ago, and this unfortunate situation. Sir, we have the ability to heal these children. We could keep them healthy. We must get them in to see the dentist. We need your help. I need it so desperately I am begging for it right now.

Mr. KUCINICH. I believe you. I think we are having a dialog here that I think is going to be very productive. I certainly appreciate your testimony.

Mr. Cummings, thank you.

Mr. CUMMINGS. Mr. Chairman.

Ms. Perkins, CMS Director Dennis Smith seemed to indicate that his hands were tied with regard to the agency's response to the States that are not complying with EPSDT for dental care. Is that your view?

Ms. PERKINS. The impression that I got from Mr. Smith's testimony was that it was being portrayed as an all or nothing alternative, either we have to withdraw all Federal funding or we don't have much power. I don't agree with that. The CMS has and States know that CMS has the power of the purse string. The Federal Government is funding from $0.50 to $0.73 out of every dollar that is spent in States on Medicaid. When CMS is serious about something and wants something done, States listen.

I think that the January 18, 2001, letter that was sent from CMS to States is just one example of that. The 49 States sent back plans of action. I have been at the National Health Law Program 22 years, and there are numerous examples of that sort.

Now, it is also true that the Secretary at Health and Human Services is, in the Medicaid Act, and has always in the Medicaid Act been charged with the responsibility of taking enforcement action when the Secretary finds that the State's plan is no longer in compliance with the Medicaid Act. There are State plans that are no longer in compliance with the Medicaid Act. The notice to the State can tell the State that the action and the funding involved is directed at the service that is out of compliance. That doesn't mean that the funding is stopped the next day. There is a process for the State to go through to have a hearing and for an impartial decision to be made ultimately about what to do about that funding.

We see in the Federal Register numerous, numerous occasions of notices where the Federal Government is saying we are not going to approve this. We don't think it complies with the act. Many, many of those cases settle, again, going back to my first point, because the Federal Government has such a powerful purse string with the Federal funding.

Mr. CUMMINGS. Ms. Perkins, it is interesting that we have seen over and over again—and I think it was Ms. Watson a little bit earlier who talked about it—the systems that are supposed to work that don't work. We see it. I see it as the chairman of the Coast Guard Subcommittee on another committee. I have seen it in this committee, Oversight and Government Reform. We have systems, but because of individuals who either are incompetent, lack empathy, negligent, or just don't care, the systems break down. I see it over and over and over again.

If you look at the problems that we have had in this country—Katrina was a good example—we are seeing it in a program called Deepwater where we spent $24 billion for some boats that don't float, in this country.

I am just trying to figure out what are the kind of things you would like to see in place so that, no matter what, when you have

the kind of problem I just talked about, lack of empathy, negligence, people who just don't care, you are going to have that, but how do you minimize that in a situation like this? Are you following my question?

Ms. PERKINS. I do. I think that the solution is already on paper, and it is what Congress has already passed in the Medicaid Act. Congress has made it incredibly clear what it wants States to do in providing early and periodic screening services to children. It has made it clear to the Secretary what kind of reporting it wants to have happen. And it has made it clear what kind of oversight it wants to have States engage in where they are contracting with capitated managed care plans that are getting paid ahead of time to provide the care that kids are going to need.

So I think that the blueprint is on paper. It isn't a matter of having the will to enforce the law and to take the law that Congress has passed more seriously, than the desire, for example, to have private accreditation companies and their HEDIS measures be what is going to be equated with quality and a well-running program.

Mr. CUMMINGS. I am going to move on to you, Dr. Finklestein. We kept hearing this term a dental home. What is the significance of that?

Dr. FINKLESTEIN. The significance of a dental home is a place that anyone—in this case, youngsters—can receive dental care 24 hours a day. Not to say the dentist is there 24 hours a day, but our contracted doctors are required to provide emergency, urgent care, and routine care.

What we have to do is seize the opportunity of the dental home. It is almost like how do we get the water where we want it. We have to go into schools. We have to start screening programs in schools and then assign these children to dental homes that are permanent. This is the model that will work. Every child should know they have a dental home. A lot of them don't. We often treat a youngster 1, 2, or 3. This is a child that is in pain. That is a child that cries himself or herself to sleep, a child with low self-esteem, a child that misses school. This is a cycle that can be ended.

If we can't get our members to come to us, we are going to have to change the model. We are going to have to get into the school systems, work with school systems, and then assign a dental home to them. That is the only way.

Mr. CUMMINGS. So is the dental home the primary?

Dr. FINKLESTEIN. It would be my practice. If you came to me, I am your dental home.

Mr. CUMMINGS. OK. Now, United deals with medical and dental; is that right?

Dr. FINKLESTEIN. Yes, sir.

Mr. CUMMINGS. Now, do we assign folks medical homes?

Dr. FINKLESTEIN. Yes, we do. We do assign a primary care physician.

Mr. CUMMINGS. And do you assign them dental homes?

Dr. FINKLESTEIN. We do not. We have open access.

Mr. CUMMINGS. Let's say Johnny Watts would be receiving medical treatment through you.

Dr. FINKLESTEIN. Yes, sir.

Mr. CUMMINGS. And receiving dental treatment through you.

Dr. FINKLESTEIN. That is correct.

Mr. CUMMINGS. Why would he have a medical home and not a dental home?

Mr. CUMMINGS. Our model throughout the country, we have found that it is easier to have access, not restrictive access. If that dentist is not there, they can call our 800 number, we can get them another dentist.

Another way, when you sign panels, most of this panel and dental home assignment came off of something that was touched up eloquently about capitation. Doctors receive remuneration to have X amount of patients, let's say 100 patients who are assigned to them, to treat them. There is no incentive to treat when you prepay.

Our model is to do a fee for service and give you access, just as you have with your—you have a plan, you have doctors, you have 700 dentists in the State of Maryland. You can choose any one of them. And if you are in need of transportation, we will get you there.

Mr. CUMMINGS. So having a dental home is your philosophy, and I guess the philosophy of your company, that it is better to not have a dental home than to have one; is that right?

Dr. FINKLESTEIN. No. We give you the dental home, but you select the doctor of your choice. You find that home. He is your dentist, or she is your dentist.

Mr. CUMMINGS. But if you can't find a dental home——

Dr. FINKLESTEIN. That is our job. That is why if you call right now there is someone answering the phone, how can we assist you, in any language that you can make up, any language in the world. We will respond and we will help them, as I said, navigate through the system.

Mr. CUMMINGS. You had said a little earlier in answer to one of the chairman's questions, you said something about 45 percent that you said that used the system had, I think, one dental screening in 2006, at least one, is that right? Was that 45 percent?

Dr. FINKLESTEIN. Yes, 45 percent of unique dental visits. Correct.

Mr. CUMMINGS. And you put your head down and said it should have been—you wished that you could have gotten the other 55 percent, or something to that effect; is that right?

Dr. FINKLESTEIN. That is my profession. My profession is to treat. That means 55 percent of my youngsters never got to see a dentist. That is unacceptable in this country. It is unacceptable.

Mr. CUMMINGS. And you believe they should have, the other 55 percent?

Dr. FINKLESTEIN. With all my heart.

Mr. CUMMINGS. Period?

Dr. FINKLESTEIN. Period.

Mr. CUMMINGS. So, in other words, everybody enrolled with United, you want to see have at least what a year?

Dr. FINKLESTEIN. Get them to baseline health, whatever it takes. You see, it is an investment. It is a good investment. The children that come in that I can get healthy and keep them healthy, then your medical loss ratio kicks in on the smart end, not on the nega-

tive end. Not treating catastrophic illness; treating preventable disease. There is nothing so preventable.

This disease, you heard, five times asthma, etc., Doctor Satcher called it the silent epidemic. It is unbelievable that we can't control. Sometimes with my colleagues I will sit and talk. We have basically two diseases to deal with, besides congenital defects, birth defects, that we found in the mouth: periodontal disease, more in adults, and decay. We can't get it under control and we have to make it mandatory that every child sees a dentist. Then we will have results. Then we will have healthy children that won't miss school, that will have self esteem, that will sleep at night, and that is it.

We also have our obstetricians. That is where we start. We have our obstetricians talking to our future moms. You can't give a bottle to this child to go to sleep. It is difficult. They have so many problems. They do not know where they are living, etc. The child is sleeping. It is so simple to give a bottle with lactic acid. That is what it breaks down. And then I have no teeth to restore. I have abscesses. I have potential disasters on my hand, all because someone—and here is the biggest problem. I am so happy you asked this question. The physicians have to buy into this. I'm tired of being the repair man. Sixty-three years of age, almost 38 years in this profession, why can't I do preventive dentistry. Why am I not rewarded for doing what is right instead of fixing what went wrong?

This is the basic premise. This is the problem in dentistry today.

Mr. CUMMINGS. You said that we don't pre-pay dentists because there would be no incentive for them to see patients; is that what you said?

Dr. FINKLESTEIN. That is correct. That is correct. That is a capitated program.

Mr. CUMMINGS. Couldn't the same be said for the pre-paying of United Health?

Dr. FINKLESTEIN. No, sir.

Mr. CUMMINGS. What is the difference?

Dr. FINKLESTEIN. The difference is when I get a child healthy in dentistry I save money.

Mr. CUMMINGS. Yes.

Dr. FINKLESTEIN. That is a preventive model. When I have a disaster, it is financially a disincentive and it affects the family, transportation. You just look at the cost. There was one mentioned. The cost of that for a simple extraction, for a simple extraction that a sophomore dental student could do? Early diagnosis, early treatment, that is EPSDT. But I need these kids. I need them terribly. I won't let you down if I get the kids. If I don't get them, I cannot treat them, sir.

Mr. CUMMINGS. So if they never get there, then it doesn't cost you anything?

Dr. FINKLESTEIN. If they never get there it costs me much. It hits on my medical end. It hits on the emergency room end. Oh, it costs me. It costs me way more than doing preventive dentistry.

Mr. CUMMINGS. I see Ms. Perkins shaking her head. You in agreement with him?

Ms. PERKINS. That is one of the measures that we use as an indicator of a broken system, how many children are getting their dental services in the emergency room.

Mr. CUMMINGS. Yes. And did you look at Maryland in that regard?

Ms. PERKINS. We were looking actually at North Carolina.

Mr. CUMMINGS. I found it interesting what you said. I just want to go back to Ms. Perkins for a moment, what you said about the South Carolina system. You seem to be very impressed with that; is that right?

Ms. PERKINS. Well, by making changes to its program, it is behind only the State of Vermont in terms of screening the most number of kids. Their rates are at the 75th percentile of dentist rates in the region. They have really focused on partnering with dentists to get them to train general dentists to provide services to pediatric cases to kids, special needs kids, so you can get services in rural areas where there are general provider shortages. They partnered with the AME churches where they have done over 110 screenings. And the screening levels have increased dramatically. That is what the end game is here. It is not how much a doctor or dentist is getting paid, but how many kids are seeing a dentist for preventive care and getting the corrective treatment.

Mr. CUMMINGS. If I yield to the chairman, then he is going to yield back to me, but let me just ask this real quick question. Who drove that plan? Who made that happen? Was it the Governor? Did it come through the State legislature? Do you know?

Ms. PERKINS. I don't know.

Mr. CUMMINGS. Well, we can find out.

Ms. PERKINS. Yes.

Mr. CUMMINGS. I yield to the chairman.

Mr. KUCINICH. Thank you, Mr. Cummings.

In the course of your discussion with the doctor, something occurred to me to ask because, again, I see this great compassion expressed for the children, which is mandatory. Now, Doctor, I have heard you say a couple of times that you can't help your kids unless they are sitting in your dental chair. I have heard you say that a few times, and I understand the spirit that motivates that statement.

Here is what I am wondering. Earlier today our staff provided me with information that said that they did a spot check of dentists that were listed in United Health Care's provider network. They called 24 dentists. The score is up on the screen there. Twenty-three of the numbers were either disconnected, incorrect, or belonged to a dentist who did not take Medicaid patients. The 24th did accept Medicaid patients, but only for oral surgery and not general dentistry. So effectively, according to the spot check by the congressional subcommittee staff, none of the numbers listed would have been of any use to Deamonte.

Help me with this. What is going on?

Dr. FINKLESTEIN. The locale? Was that Prince George's County?

Mr. KUCINICH. Yes, sir.

Dr. FINKLESTEIN. OK. I can only give you my statistics. I am not finding any——

Mr. KUCINICH. I want you to explain that, though. I mean, help me.

Dr. FINKLESTEIN. I will. I will explain it the way I can see it.

First of all, I would have to look at the access availability studies, because we do those also. We also have something called a silent shopper. We make appointments. This is done. We report this to the State. We constantly do access and availability.

But the number that sticks in my mind—now, I am not finding fault with the survey, because I really haven't studied it—is that in Prince George's County last year, 2006, United Health Care paid unique claims to 78 dentists that are in our network, 78 dentists, and we can share this information with you, received payment from us as par, meaning participating, dentists.

Mr. KUCINICH. Is it possible that any of the information that is in that list on the provider network could be incorrect?

Dr. FINKLESTEIN. It is interesting. My windshield was broken on the way down and I called to make an appointment to have my windshield fixed. I called the Yellow Pages. It was a wrong phone number, and it was the recent directory. I went to this place in New York prior. Is it possible? Perhaps.

Mr. KUCINICH. Hopefully you would have a better batting average with repairing your windshield than our staff did with trying to find a provider.

Dr. FINKLESTEIN. I would hope so.

Mr. KUCINICH. Now, this was on your Web site, I might add, which hopefully has high reliability. I think it is important for us to look at that, because, while I believe you when you say you want to get those kids sitting in a dental chair, I think it is really important to try to square that with the apparent lack of availability. It came from, admittedly, a single study, but, nevertheless, I would guess that if we did a second study, it would probably be pretty close, if we called the same numbers, probably pretty close response to what we had the first time. So I wanted to call that to your attention——

Dr. FINKLESTEIN. Yes, sir.

Mr. KUCINICH [continuing]. Because I think that what I would like to do to staff is to have staff review this with the doctor so that you should know what we found.

Dr. FINKLESTEIN. Absolutely.

Mr. KUCINICH. And I would be happy to share it with you so that maybe we could have a greater understanding as to how that could occur.

Now, part of your job, Doctor, is to create a dental provider network.

Dr. FINKLESTEIN. Yes, sir.

Mr. KUCINICH. We talked about the dental house. What have you done to broaden the dental provider network?

Dr. FINKLESTEIN. The basis, first of all, we are getting more pediatricians involved in early screening, early recognition of disease, and then we also have a reimbursement for a wonderful program for fluoride varnish. A lot of decay that is in a youngster's mouth can, believe it or not, be arrested and reversed. It is a whole new concept. It is not as new as we think, but it took the American Dental Association to 2007 to finally give me a code that I can re-

imburse on. That just happened January 1, 2007. But we are including pediatricians in this now.

Mr. KUCINICH. Yes.

Dr. FINKLESTEIN. So we are broadening the denominator of providers. We also have to get to the medical schools. They have to learn what the disease entity in the mouth is. It is so simple to look at the throat and beyond. They do not look that carefully at teeth. I am not finding fault with my colleagues, but I am finding fault with them. It is just the same thing with my colleagues on the dental end. There are systemic linkages between periodontal disease and systemic disease. We have to take this further.

If I can prevent one prenatal birth, one low birth weight, perhaps, I want healthy new moms giving birth.

But let me get back, because I will start talking dentistry and we will be here until midnight. The piece that we do when I recruit—and I do a lot of recruiting hands-on. I like my providers to have my telephone number. I like them to have my pager number. I want to be involved in patient care. That is really my life. The statistics you asked for, that will come. That is not my life. My life is the kids.

What we are doing now is you have to see not every dental provider is the same. You have to have unique ways of contracting. Reimbursement, and then measure their outcomes. Doctor, you don't know how they love when I say no more pre-authorizations, no more you are getting this rate. We are going to make it so you are a total partnership. We only do a retro review to make sure our children are having the right outcomes. This is the uniqueness of it.

Yes, you have to have a fee differential and, as was stated our Medicaid rates in Maryland have gone up. They have gone up throughout the country. We are recruiting. We have a more robust network than we ever had before.

Mr. KUCINICH. So when you say outcomes, you mean on the care to the patient?

Dr. FINKLESTEIN. See, that is a better measure than HEDIS.

Mr. KUCINICH. But do you also measure their outcomes with respect to whether someone's care for a patient exceeds a certain threshold that goes beyond the capitation?

Dr. FINKLESTEIN. We don't do capitation.

Mr. KUCINICH. Beyond the fee for service.

Dr. FINKLESTEIN. Yes, obviously.

Mr. KUCINICH. Right.

Dr. FINKLESTEIN. Obviously.

Mr. KUCINICH. And that has never had a bearing on whether someone is in the provider network?

Dr. FINKLESTEIN. It is medical and dental. You have to——

Mr. KUCINICH. But I mean has that ever had a bearing as to whether or not someone is invited to be in or out of your network?

Dr. FINKLESTEIN. No, no. The barrier's could be if they are fraudulent, obviously, if they are fraudulent, but that is certainly a barrier. But the best way is to discuss and try to find out. What I see on a claim and radiographs, I am not the treating dentist, so I sit, we talk. Let's find out what is going on.

Mr. KUCINICH. Mr. Cummings.

Mr. CUMMINGS. Did you hear Ms. Norris' testimony?

Dr. FINKLESTEIN. Yes, sir.

Mr. CUMMINGS. Did you hear her talk about the hoops that she had to go through to get a dentist in this case? I am not asking you to talk about this; I am just asking did you hear her testimony.

Dr. FINKLESTEIN. I heard it, sir.

Mr. CUMMINGS. How did that make you feel?

Dr. FINKLESTEIN. I would just say could you take the member's card, could you dial the 800 number and see if I failed you. Let us navigate it. Let us get the appointment. Let us be the health insurer. That is all I am asking for. If you want a test, check the 800 number, and that is how you check access to care.

Mr. CUMMINGS. I don't have her testimony in front of me, but——

Dr. FINKLESTEIN. I heard it.

Mr. CUMMINGS [continuing]. It seems like she did that. She did all those things. She is back there shaking her head, by the way.

Dr. FINKLESTEIN. I don't know, sir.

Mr. CUMMINGS. Let me tell you where I am. The chairman has heard more of your testimony than I have. I was at another meeting, and so I didn't hear all of your testimony. He has concluded that you are a very caring person, and I believe that. What I find difficult to synchronize is numbers like that and the caring person that he has just described.

Dr. FINKLESTEIN. Yes, sir.

Mr. CUMMINGS. I understand that there are a lot of people that work for your company. I understand that. Because this is the bottom line: if I make a commitment to do something and, for whatever reasons, don't have the capability of delivering it, that is a problem. And when you see numbers like that, I can be the most loving, caring person in the world, but if I can't deliver, that is a problem.

So I guess what I am trying to say to you is, the chairman asked you about what you do to try to improve numbers like that. I would imagine that after this case you all did some things, but are things better in Maryland? Is that a fair question?

Dr. FINKLESTEIN. Yes.

Mr. CUMMINGS. Are they better?

Dr. FINKLESTEIN. Yes, they are better in Maryland, but, on the other hand, we have some models in other States that are time that we make some changes in the Maryland model. You weren't here, sir, when I spoke about our Rhode Island model. It is a change. What we did is we took EPSDT, which is kind of restrictive, and mixed it into a commercial model, and we came out with a blend that dentists can live with. It is time. It is working there. It only started September 1, 2006. We didn't get full enrollment of 32,000 youngsters until November 1st. And now the State is so pleased that they are trying to increase more membership to United on this model.

Whatever I do has to be re-evaluated not only by you but by myself. My outcomes have to constantly be evaluated. When I have a patient come back to me, as I had this past Saturday, of 40 years, and I saw a restoration, a filling that I did 40 years ago, that is pride. I have to put the pride back into this program, sir. If there

is anything that I can do—and you used the word commitment. That is what I am pledging to you today is my commitment to make this program better throughout the country—that is, Medicaid—working with you and anybody else in collaboration, because it is unacceptable to have a result as we had that you read in the newspaper. That is unacceptable.

Mr. CUMMINGS. In fairness to Ms. Norris—and I just want us to be clear—I just want to read a little bit of her written testimony.

Dr. FINKLESTEIN. Yes.

Mr. CUMMINGS. She's talking about DeShawn, now, that DeShawn was enrolled in Maryland's Medicaid HealthChoice program, and his managed care plan was United Health Care. "I called United Health Care's customer service number."

Dr. FINKLESTEIN. OK.

Mr. CUMMINGS. The number I guess you talked about, 1–800. "From there, I was transferred to the plan's dental benefits administrator, a separate company called the Dental Benefits Providers, or DBP. A very helpful customer service representative explained that DeShawn would first have to see a general dentist to get a referral to an oral surgeon in order to get the treatment he needed. She also explained that the Medicaid part of United Health Care Company was called AmeriChoice, and that this was the company the dentist would be contracted with, not United Health Care."

Dr. FINKLESTEIN. You just hit it right on the head. It is convoluted.

Mr. CUMMINGS. Yes.

Dr. FINKLESTEIN. I have to look into it. I have to look at root cause analysis on that.

Mr. CUMMINGS. Yes.

Dr. FINKLESTEIN. There is confusion and there shouldn't be confusion.

Mr. CUMMINGS. And I am telling you that when people—Dr. Finklestein, I have lived in the inner city and refused to move from the inner city for 56 years. I live where a lot of the people that we are talking about live, by choice. A lot of these folks, just trying to get from day to day is a struggle.

Dr. FINKLESTEIN. Admittedly.

Mr. CUMMINGS. It is a struggle. So then when they have to go through these kind of hurdles, I am amazed that they got as far as they got. I am just being very frank with you. We can say what we want about them, but the fact is that is reality. So all I am saying is I think it is very clear that we have to find—first of all, nobody should have to go through what Ms. Norris did. Now, she is a professional, and if she is frustrated, a professional now, imagine somebody who is doing it on their own.

So then the question becomes, if I have this product—and this is assuming I have a product to get them to—and if they have to go through 50 million changes to get there, they may never get there. And, as she said, once they get there, then there is no there. That is a problem. That is why it is very difficult for me to sit here and feel—I have to tell you, I am just being frank with you. It is hard for me, when I try to synchronize the way the chairman has talked about you so nicely, and then to see what ends up.

I have just got a few more questions, Mr. Chairman. I can see you are getting anxious over there, but I am almost finished.

I want to go to you, Ms. Tucker. I want to thank you for appearing before our committee here today, and I know it has not been easy. I realize that. I do appreciate your willingness to speak candidly, and I do appreciate all the things that Governor O'Malley is doing trying to straighten this situation out. I understand there has been legislation that has been passed, and the question becomes funding for the legislation. I am just wondering where that stands. I have been told by some of the people who have looked at Maryland that we have legislation but there is no money to do it with. Can you comment on that? Will you comment on that, please?

Ms. TUCKER. There was legislation this year to fund increased public health dental outreach efforts, and there wasn't funding attached to the legislation, and we are looking at alternative ways to do some of those activities, even without the funding that was attached.

For example, there is a Maryland Health Resource Commission that gives out grants. It has funding to give out grants to try to improve health care access to different kinds of services. We are going to be working with that Commission to see if they will do a special solicitation for dental services and to try to fund some of what was not funded in the legislation. It was originally $2 million, to try to fund it through other mechanisms like that.

Mr. CUMMINGS. Well, we are going to hold you to it. I mean, that is just very important. I realize we are dealing with the legislature, and I used to be in the legislature, so I know how that goes, but we have a situation here where we don't want to see another one of these situations come forward. In the meantime, I think, as I said to some other folks, I do believe sadly these incidents like this happen, and it is very, very unfortunate, but it also is supposed to shine a bright light on places we need to go and things we need to address.

Ms. TUCKER. I agree with you.

Mr. CUMMINGS. Speaking of bright lights, I know that you have a list of strategies, which sounds very good, but one of the things that I did not see was oversight of managed care organizations. Is that a part of your——

Ms. TUCKER. That was actually the second part of my presentation. We do a lot of activity.

Mr. CUMMINGS. Did you make that presentation?

Ms. TUCKER. I did.

Mr. CUMMINGS. OK.

Ms. TUCKER. But we do monitor the utilization of encounter data. We actually require managed care organizations in our State to submit every medical encounter that occurs for all recipients, so we do look at that to look at how many individuals receive care, all different kinds of care, not just dental care.

We require annual outreach plans. We review them carefully. They have to have a dental section. They have to have materials that they send to recipients. We review those for literacy and for how they are going to do that. The United dental outreach plan also includes incentives, $10 incentives for families who take their

children in for a checkup, for example. There are all these different strategies. So there is this outreach plan that we review.

Mr. CUMMINGS. Let me ask you this: how much control does the Health Department, the State Health Department, have over the validity of the MCO's listed practitioners?

Ms. TUCKER. We monitor the MCO encounter data very carefully. This is not data the MCOs make out; this is data that providers submit. We run it through a rigorous review, just like we review all our claims data that comes in to our system, to look to make sure that the provider is on the file, that the procedure makes sense, that there is not duplicate procedures going through the system, etc., so that we can then do the measures to look and see what is happening with our recipients.

The thing that is not the best about it is that it is not like an electronic medical record. It is not real time. So it is hard to use it for tracking and for looking to see if children need services immediately, because what we are doing is the provider is billing United or AmeriGroup or any of our MCOs, and then they are forwarding the provider's claims data to the State.

Mr. CUMMINGS. Let me tell you something, Ms. Tucker. There is no one that I know of in the United States that is better at tracking than Governor O'Malley.

Ms. TUCKER. I understand that.

Mr. CUMMINGS. I am just saying I don't know of anybody.

Ms. TUCKER. Right.

Mr. CUMMINGS. All I am saying is maybe you ought to talk to the Governor, because there may be some things that he can bring to this process that might help us.

Ms. TUCKER. It is the whole——

Mr. CUMMINGS. I know it is very complicated. I understand that.

Ms. TUCKER. Yes. Electronic medical records is a whole——

Mr. CUMMINGS. I understand. I understand. He is the master of that.

Ms. TUCKER. Right.

Mr. CUMMINGS. Let me ask you this, and this is just one last thing. First of all, let me go back to the chairman. I really do appreciate his can-do attitude. When Democrats took over the Congress, one of the things that we were very concerned about is accountability, but we are also very concerned about results. What the chairman has said, as I heard him, is we are trying to figure out results that come out of all of this. We just don't want to be meeting here until 9:30 or 9. So I don't know how all this works, but you have Dr. Finklestein saying that he wants to do everything in his power to help the situation—am I right?

Dr. FINKLESTEIN. Yes, sir.

Mr. CUMMINGS. And you have experts like Ms. Perkins, who has given wonderful testimony. I mean, is there things that you all can do working together to come up with some solutions? Let me tell you something. Let me tell you what is so frustrating about being here in the Congress. I'm sure the chairman will agree with me. Sometimes, as much as we like to make laws, it takes time.

In the meantime, when people can resolve matters, that is nice, but it takes time. I am hoping that there are some things that you all can do. That is not to say that Congress will not act and do

some things, but there are some things that perhaps you all can do working together with others in your situation, Dr. Finklestein, to help remedy some of these problems.

I take it that you have taken some steps since this case came up and you are doing some things. I was just wondering, do any of those things involve companies like United and the others?

Ms. TUCKER. The action group that we are pulling together has a full array of stakeholders, including MCOs, including dentists, including parents, public health professionals, so it is going to have a full array of stakeholders, including individuals like Ms. Norris, advocates. So we are pulling together this action committee.

Mr. CUMMINGS. And would you ask them to take a look at the South Carolina model?

Ms. TUCKER. We can definitely look at any models. What we want to do is get the group together to look at all the different issues, and we want them to come up with an action plan quickly so that they can get recommendations to the Secretary by September, which is still time for possible budget initiatives for next year. That is why the timing is kind of a rapid turn-around. Definitely we can look at South Carolina.

Mr. CUMMINGS. Like I said, I think that as a citizen of the State of Maryland I can tell you I want a person like Ms. Perkins to come before a committee and say, you know what? Everybody ought to be like Maryland. Maryland is a leader in health care and everybody ought to be like Maryland. I think that is so important. As I say many times, if we can send people to the moon, we ought to be able to do these earthly things and pull folks together to make things work.

So I want to thank you all for your testimony. I know the chairman is going to say a few other words, but I want to thank you all. I don't ask, because asking is simply too cheap; I beg you to address these issues. We just can't have this. We can't. This is America. It doesn't work that way and we shouldn't have this.

Thank you all.

Mr. KUCINICH. Thank you, Mr. Cummings. I want to thank you for all the work that you have done today and in cooperating to put this hearing together.

We can send someone to the moon, but the question of this hearing is can we send a child into a dental chair. According to the Congressional Research Service, of the 502,000 Maryland children eligible for Medicaid in 2005, 75 percent, or 375,000, did not receive even one preventive dental service during the year.

What is the State's plan for accelerating its rate of improvement?

Ms. TUCKER. As I outlined in my testimony, what we are doing is we are pulling together this Dental Action Committee to look at all sorts of strategies. Medicaid agencies can't do this by ourselves. We need the dental community to be involved, the provider community. We need parents to be involved. We need Federal policymakers like you all to help us with funding for some of the safety net connects to make sure that federally qualified health centers have dental suites, to consider screening in schools. We need your help.

Mr. KUCINICH. So would you agree that there is a connection between low dental payment rates for providers and the lack of access to the dental chair?

Ms. TUCKER. I definitely think there is a problem, but it is not the whole problem. For example, Ms. Perkins just talked about the District of Columbia. They have the highest rate in the area, and yet their dental utilizations seem to be very, very poor.

We have tried to work on improving dental rates, but our rates are still low in Maryland.

About 2 or 3 years ago the State of Maryland decided to finally bring physician rates up to the Medicare rates. Our physician rates had lagged for years and years and years, and some of them were 10 percent of Medicare rates they were so low. The legislature decided to tackle that and provide over a 5-year funding to try to bring us up to 80 percent of Medicare.

Mr. KUCINICH. Now let's——

Ms. TUCKER. We need to do the same kind of thing with dental. We need——

Mr. KUCINICH. OK. So here is the question: has the Department required managed care organizations to beef up their provider networks with dentists who will actually accept as patients the low-income children for whom the managed care organization has responsibility for managing care?

Ms. TUCKER. I think that I have heard a lot of very distressing testimony about the dental networks. We do know that there are 918 unduplicated dentists in the networks that the MCOs use. We do know that those dentists do bill. What that means is that they have accepted Medicaid patients, that they are seeing Medicaid patients, but what it doesn't mean is that they are open to new patients necessarily, which is bad.

Mr. KUCINICH. We had Dr. Tinanoff looking at 19 of Maryland's 23 counties, and he found that, of 743 listed dentists, only 170 are willing to accept new Medicaid patients.

Ms. TUCKER. New patients. I agree. And we have to look at a different way to give information to patients. Rather than giving them lists of providers who have contracts with MCOs, we are going to have to look at, instead, not giving them lists of providers that have contracts, but actually actively linking them with a dentist that does accept new patients.

Mr. KUCINICH. The next question is how can the Department expect parents to find dentists for their children if the information that is provided isn't reliable?

Ms. TUCKER. I totally agree. One of the things that we are doing is we are meeting tomorrow with the MCOs to talk about all of the dental issues that have come up in the hearing today, and that we have been talking about actually over the years and during the last 2 months. This is going to be one of the top items on the agenda.

Mr. KUCINICH. So has the Department required these managed care organizations to demonstrate improved outcomes in the dental health of low-income children for whom they have the responsibility for managing care, such as a reduction of untreated cavities?

Ms. TUCKER. That is a really hard measure to get at. What you would have to do is you would have to do actual oral exams of Medicaid patients to then measure that. What we try to do is look for

measures where we can get data. But this is something that we are going to need to talk to, again, with our Action Committee to see if there are some other measures that we might be able to use in addition to the HEDIS measure.

The reason that we do use the HEDIS measure is because it is the only way we can compare our performance with other States. It is the only measure that the managed care system uses across the board, and so that is the measure we have used, but it doesn't mean it is the ideal measure or it is an outcomes oriented measure, so it is something that we should talk about in our action committee.

Mr. KUCINICH. So do you regularly check the number of providers still? Do you run a constant canvass on the number of providers? How often do you update your number of providers?

Ms. TUCKER. I actually am not sure how often we do that. I do know that we look to see if the providers are billing, and we do look to see if they have contracts with the MCOs. But I am not sure that we do regular checks in terms of whether or not they are open. I know that they open and close frequently. It is very frustrating in trying to monitor that situation.

Mr. KUCINICH. Well, do you think it would be helpful if you found a way to be in contact or have some vehicle for contacting providers so you would be able to really know how many providers you have, and therefore you could guess how many people are going to be able to have access to some of these?

Ms. TUCKER. We can try to set up a program. It is only going to be as good as the day you do the calls, because they open and close at will, based on their current case load.

Mr. KUCINICH. In your testimony you talked about you made 20 calls?

Ms. TUCKER. I did not. It must have been someone else's testimony.

Mr. KUCINICH. OK. I would like to ask Ms. Perkins a question about D.C. You talked about the accuracy of lists?

Ms. PERKINS. Yes.

Mr. KUCINICH. How accurate are those lists?

Ms. PERKINS. We have looked at them on a couple of different occasions in March 2005. Let me just say that it was very difficult getting these lists in the first place from the District, who was having great difficulty getting them from the managed care organizations, but of the 135 unduplicated dental providers named, only 45 individual dentists and one clinic confirmed that they accepted Medicaid eligible children, that is even to take one child. It doesn't say anything about the extent of participation.

And of those 45 dentists, 29 were general dentists, 6 were oral surgeons, 3 were pediatric dentists, and there was one orthodontist. When you check that one orthodontist, there were four plans. There were two MCOs in the District who had no orthodontist on their plan.

Mr. KUCINICH. And you did testify that only 16 percent of children received any dental treatment services at all with respect to in States that were reporting to the CMS.

Ms. PERKINS. In 2004. We could not use 2005 data because, although it appears that the GAO was able to get access to addi-

tional data that is not publicly available, there are 15 States missing in the public data.

Mr. KUCINICH. What was the percentage of dentists you say that participate in Medicaid? Did you say 5 percent overall?

Ms. PERKINS. In the District of Columbia, 5 percent of licensed dentists. Again, that is just meaning that they take one person. It doesn't say how active that participation is, whether they have age cutoffs for the number of kids they are going to serve, or whether they limit the number of patients they are going to serve.

Mr. KUCINICH. And I want to ask a question to Ms. Tucker. Thank you. In your contract with United Health Care there is a managed care reimbursement clause that states that "The Department has the authority to recover any over-payments made to MCOs." The contract does not define over-payments. Do you consider the capitation payments made for children who do not receive services that they need, such as Deamonte, do you consider that an overpayment?

Ms. TUCKER. No, sir.

Mr. KUCINICH. And how many years would have to pass during which children did not get the services they needed for it to be considered that an overpayment has been made?

Ms. TUCKER. There is no time limit. That isn't the methodology for developing it, a capitation rate. A capitation rate is based on the general population in the program, and it is more of an average rate for individuals in different groups.

Mr. KUCINICH. I understand, but what do you do with children who chronically receive no services? I mean, does the State hold these managed care organizations accountable by recovering payments made for children who chronically receive no services?

Ms. TUCKER. We don't. It is not a fee for service program, so we don't do a cost settlement based on each individual child, just like we don't pay them more if they spend more on other individuals. That is not the way capitation works. That is not the way insurance works. We are not just paying them for providing those services; we are providing them for taking risks for catastrophic services, as well. It is all built into the capitation rate.

Mr. KUCINICH. OK.

Ms. TUCKER. So, again, it is not a fee for service program, and it is not a program with—no insurance is a program where, when you are paying for insurance, other than a fee for service, no insurance program is one where you pay for the individual patient's cost, or capitation program.

Mr. KUCINICH. OK. I think we are at the point where we are going to be soon concluding this hearing, and I want to thank all of those who came here to testify and participate in what has been a very long day on a very critical subject.

I think that, Mr. Cummings, you would agree that, with the individuals on this committee who have participated from this afternoon, that there is a high degree of interest in looking at some policy issues here where Congress can effectively participate to make sure that the case of Deamonte is never going to be repeated.

Before I conclude, would you like to say something?

Mr. CUMMINGS. I would just like to thank our witnesses. I know it has been a very long day. If there are things that you all want

to submit—Ms. Tucker, you, in particular, I noticed some things in your testimony—but if there are things that you want to submit as to what we can do to help move this process along, we would ask that you submit it as soon as possible. There may have been some things that you heard today that caused you to say well maybe this is something the Congress needs to look at. We just want to be effective and efficient and make a positive difference.

Thank you all very much.

Mr. KUCINICH. Thank you, Mr. Cummings.

I am going to just have a final word here.

In the United States of America we spend approximately $2.2 trillion a year on health care. That is about 16 percent of our gross domestic product. About 31 cents on $1, according to a Harvard University study, goes for the activities of the for-profit health care sector for corporate profits, stock options, executive salaries, advertising, marketing, the cost of paperwork, 15 to 30 percent in the private sector as compared to Medicare's 2 to 3 percent.

If the United States had a health care program where it was not for profit and we took the approximately $660 billion a year that is spent in for-profit medicine and put it into a not-for-profit system, we would have enough not only to meet all medical needs but to provide every child, and every American, for that matter, with fully paid dental care, fully covered, vision care, mental health, long-term care, prescription drugs that, in fact, Americans are already paying for this. They are not getting it. We are talking about a system that would have no premiums, co-pays, deductibles. This is the essence of the Conyers-Kucinich bill, H.R. 676.

I mention that because when I think of the doctor's commitment to children, I share that same commitment. I think of how we may some day in this country create a system where everyone is covered, and then people aren't chasing around trying to find someone because every dentist would be required to provide care and they would receive a fair reimbursement.

So it may be that down the road there is only going to be one solution to this, but in the meantime we have a lot of work to do. The witnesses here have all helped us provide some very detailed definition to the work that is cut out for us.

I think it is worthy of our efforts to devote our continued work to the memory of Deamonte, because this little boy whose life demonstrated a total breakdown of a system, maybe what we can do is provide some deeper meaning that can help children everywhere get the care they need.

Thank you.

I am Dennis Kucinich. This is the Subcommittee on Domestic Policy. I am here with Congressman Cummings from Maryland. We have held a day-long and into-the-evening hearing on evaluating pediatric dental care under Medicaid.

I want to thank all the witnesses.

This committee is adjourned.

[Whereupon, at 9:15 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Edolphus Towns and additional information submitted for the hearing record follow:]

Remarks of Congressman Edolphus "Ed" Towns before the Subcommittee on Domestic Policy Hearing on the "Adequacy of Pediatric Dental Programs for Medicaid Eligible Children"

May 2, 2007

MR. CHAIRMAN, THANK YOU FOR CALLING THIS HEARING ON THE IMPORTANCE OF PRESERVING AND EXPANDING DENTAL CARE FOR MEDICAID POPULATIONS. I WANT TO MAKE MYSELF PERFECTLY CLEAR. GUARANTEEING DENTAL CARE FOR CHILDREN UNDER MEDICAID AND SCHIP, AS WELL, MUST BE A PRIORITY OF THIS CONGRESS. WE ARE MOVING IN THIS DIRECTION ON THE ENERGY AND COMMERCE COMMITTEE IN TERMS OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND YOUR HEARING TODAY REINFORCES OUR WORK AND WHAT WE MUST DO UNDER MEDICAID.

TO PUT IT BLUNTLY, WE MUST HAVE MANDATORY AND ACCESSIBLE DENTAL BENEFITS TO PROTECT OUR CHILDREN'S HEALTH BECAUSE TOOTH DECAY IS THE MOST PREVALENT AND PREVENTABLE DISEASE FOR OUR NATION'S CHILDREN.

WHAT HAPPENED TO DEAMONTE DRIVER IN THE STATE OF MARYLAND WAS BOTH UNNECESSARY AND A FUNCTION OF REAL PROBLEMS WITHIN OUR NATION'S HEALTH SYSTEM. INDEED, DEAMONTE'S UNTIMELY DEATH EXPOSED THE ADEQUACIES WITH OUR NATION'S HEALTH PRIORITIES. IF EIGHTY PERCENT OF ALL TOOTH DECAY IS FOUND IN 25 PERCENT OF OUR CHILDREN, WHY CAN'T WE MAKE SURE

THESE CHILDREN, MOST LIKELY THOSE WHO'S PARENT'S FALL WITHIN MEDICAID, HAVE ACCESS TO AND USE THE DENTAL FACILITIES IN THEIR RESPECTIVE COMMUNITIES. HOWEVER, DESPITE THE MAGNITUDE OF NEED, DENTAL COVERAGE REMAINS AN OPTION. THIS CANNOT CONTINUE BECAUSE DENTAL DISEASE IF LEFT UNTREATED CAN IMPEDE A CHILD'S ABILITY TO COMMUNICATE, EAT, LEARN AND ULTIMATELY IN DIAMONTE'S CASE, IT TOOK HIS LIFE. MILLIONS OF OTHER LOW-INCOME, MINORITY CHILDREN SUFFER FROM DENTAL DISEASE. WE DO NOT WANT TO BE BACK HERE NEXT YEAR SPEAKING ANOTHER NAME IN THE LITANY OF PREVENTABLE DEATHS.

THE FACT IS THAT ALL STATES HAVE RECOGNIZED THAT POOR ORAL HEALTH AFFECTS CHILDREN'S GENERAL HEALTH. THAT'S WHY THEY HAVE OPTED TO PROVIDE DENTAL COVERAGE WITHIN THEIR MEDICAID AND SCHIP PROGRAMS. *HOWEVER, DENTAL COVERAGE IS OFTEN THE FIRST BENEFIT CUT WHEN STATES SEEK BUDGETARY SAVINGS. THIS MUST NOT CONTINUE.*

OUTREACH AND ENROLLMENT OF ALL ELIGIBLE CHILDREN IN DENTAL CARE MUST BE OUR TOP PRIORITY. MORE THAN NINE MILLION CHILDREN REMAIN UNINSURED AND NEARLY TWO-THIRDS OF THOSE CHILDREN ARE CURRENTLY ELIGIBLE BUT NOT ENROLLED IN MEDICAID OR SCHIP. THAT MEANS NO DENTAL CARE FOR MANY CHILDREN AND THEIR FAMLIES.

A RECENT STUDY FOUND THAT 12-MONTHS OF CONTINUOUS COVERAGE IN MEDICAID AND SCHIP SUBSTANTIALLY IMPROVES ACCESS TO DENTAL CARE COMPARED TO CHILDREN WITH EITHER NO COVERAGE OR PARTIAL COVERAGE. THAT MEANS BY THE AGE OF ONE, EVERY CHILD SHOULD HAVE A "DENTAL HOME" THAT PROVIDES FOR APPROPRIATE DIAGNOSTIC, PREVENTIVE AND RESTORATIVE CARE. WE THEREFORE MUST MAKE DENTAL CARE BOTH MANDATORY AND A PRIORITY TO IMPROVE OVERALL HEALTH CARE FOR OUR CHILDREN.

I WOULD NOW LIKE TO ASK A FEW QUESTIONS OF MEMBERS OF THIS DISTINGUISHED PANEL.

WHAT IS THE BEST WAY TO ENSURE THAT STATES PRESERVE DENTAL CARE WITHIN BOTH MEDICAID AND SCHIP?

IS IT POSSIBLE TO MAKE MEDICAID AND SCHIP WORK TOGETHER TO GET THE BEST POSSIBLE DENTAL CARE FOR KIDS IN MEDICALLY UNDERSERVED COMMUNITIES?

HOW CAN WE WORK TOGETHER WITHIN MEDICALLY UNDERSERVED COMMUNITIES TO HIGHLIGHT THE IMPORTANCE OF APPROPRIATE DIAGNOSTIC AND PREVENTIVE DENTAL CARE FOR CHILDREN?

DOUGLAS F. GANSLER
Attorney General

KATHERINE WINFREE
Chief Deputy Attorney General

JOHN B. HOWARD, JR.
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DANIEL J. O'BRIEN
Principal Counsel to the Department of Health and Mental Hygiene
Assistant Attorney General

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TIMOTHY J. PAULUS
Deputy Counsel
Assistant Attorneys General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
Department of Health and Mental Hygiene

FAX NO.

April 27, 2007

WRITER'S DIRECT DIAL NO.

BY FAX AND FIRST CLASS MAIL

Noura Erakat
Counsel
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Dear Ms. Erakat:

I am writing on behalf of Susan Tucker, Executive Director, Office of Health Services, Maryland Department of Health and Mental Hygiene ("Department"), in response to your letter to her, dated April 17, 2007. In that letter, you requested information relating to availability of dental services to Medicaid-eligible children. I address below, each of your specific requests for information.

1. You requested a copy of the contract between the Department of Health and Mental Hygiene and United Health Care of the Mid-Atlantic ("United"). The Department has previously provided you with the contract template for all Maryland managed care organizations. A copy of a signed United contract is enclosed.

2. You requested the amount paid on a monthly basis by the Department to United on behalf of Deamonte Driver during the period of his enrollment in United. Information about specific Medicaid recipients is confidential under Maryland and federal law and may not be released without the consent of the person to whom the information pertains or that person's guardian. Maryland State Government Article, Code Ann., § 10-617; Annotated Code of Maryland, Art. 88A, § 6(a), (f); 42 U.S.C. § 1396a(a)(7).

3. You inquired about the number of children under age 21 enrolled in United during calendar year 2006. The average number of children under 21 enrolled in United each month in CY 06 was 92,073. This compares to 408,135 for the entire HealthChoice population.

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4. You inquired about the total amount paid by the Department to United on for calendar year 2006. The Department paid United $239.3 million in 2006.

5. You requested a number of items concerning United's revenues, costs and earnings. The Department does not have all of the cost figures you requested. All of the other information is confidential commercial information that may not be released under Maryland law, Maryland State Government Article, Code Ann., § 10-617(d).

6. **You requested a list of covered dental services by code and the fee schedule for those services in effect for 2006. That information is available on the Department's website at http://www.dhmh.state.md.us/mma/providerinfo/pdf/dentalfee1106.pdf.**

Sincerely,

Joel Tomari,
Assistant Attorney General
Counsel, Maryland Medical
Assistance Program

MANAGED CARE ORGANIZATION
HEALTHCHOICE PROVIDER AGREEMENT

THIS AGREEMENT (the "Agreement"), effective this 1st day of, January, 2000, is entered into by and between the Maryland Department of Health and Mental Hygiene (the"Department") and United HealthCare of the Mid-Atlantic Family First (the "MCO"), a Managed Care Organization with authority to conduct business in the State of Maryland.

WHEREAS, the Department has established the Maryland Medicaid Managed Care Program, also known as the Maryland HealthChoice Program ("HealthChoice"), a waiver program authorized by the Health Care Financing Administration ("HCFA") of the U.S. Department of Health and Human Services ("DHHS") under §1115 of the Social Security Act and authorized under Maryland Annotated Code, Health-General Article, §§15-101 et seq.

WHEREAS, the Department desires to provide health care services to Medicaid recipients through the MCO.

WHEREAS, the MCO is engaged in the business of arranging health care services.

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained, the parties hereto agree as follows:

I. THE MCO AGREES:

A. To comply with the regulations of the HealthChoice Program at COMAR 10.09.62-10.09.74, several of which are specifically referenced herein, as well as any other applicable regulations, transmittals, and guidelines issued by the Department in effect at any time during the term of this Agreement.

B. In accordance with COMAR 10.09.63.02, to accept enrollments by the Department of HealthChoice-eligible Medicaid recipients (the "Enrollees") up to the maximum numbers specified in Appendix A of this Agreement, and each update to Appendix A.

C. To enter into a contract with any historic provider assigned to the MCO by the Department in accordance with COMAR 10.09.65.16.

D. To maintain, and assure that its subcontractors maintain, adequate records which fully describe the nature and extent of all goods and services provided and rendered to Enrollees, including but not limited to, medical records, charts, laboratory test results, medication records, and appointment books for a minimum of six (6) years, and to provide certified copies of medical records and originals of business records upon request to the Department and/or its designee, the

Medicaid Fraud Control Unit, the Insurance Fraud Division of the Maryland Insurance Administration, or any other authorized State or Federal agency, or as otherwise required by State or Federal law or regulation, or pursuant to subpoena or court order.

E. To permit the Department, the Maryland Insurance Administration, and/or DHHS, or any of their respective designees to:

1. Evaluate the quality, appropriateness, and timeliness of services performed through inspection, market conduct reviews or other means, including accessing the MCO's and its subcontractors' facilities using enrollment cards and identities established in the manner specified by the Department. As to market conduct reviews, the costs incurred by the Maryland Insurance Administration will be the responsibility of the Department.

2. Inspect and audit any financial records, including reimbursement rates, of the MCO and any of its subcontractors relating to the MCO's capacity to bear the risk of potential financial losses, as required by 42 C.F.R. §434.38.

F. To protect the confidentiality of all Enrollee information, including but not limited to, names, addresses, medical services provided, and medical data about the Enrollee, such as diagnoses, past history of disease, and disability, and to not release such information to a third party except upon the consent of the Enrollee or the Department, or as otherwise permitted by State or Federal law or regulations, or pursuant to a court order.

G. To provide information which is necessary to achieve the purpose of coordinating care and delivering quality health care to the MCO's enrollees, to the Administrative Services Organization (ASO) of the Specialty Mental Health System or to any other entity that the Maryland Medicaid Program so directs.

H. Not to prohibit or otherwise restrict a health care professional, with a contractual, referral, or other arrangement with the MCO, from advising an Enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under this Agreement, if the professional is acting within the lawful scope of practice.

I. Not to discriminate against a recipient on the basis of the recipient's age, sex, race, creed, color, marital status, national origin, physical or mental handicap, health status, or need for health care services. (COMAR 10.09.65.02.H(2)).

J. To comply with the standards in the Americans with Disabilities Act, 42 U.S.C. §12101 et seq. (COMAR 10.09.65.02.H(1)).

K. To accept as payment in full the amounts paid by the Department in accordance with COMAR 10.09.65.19 and 10.09.65.22 (stop loss), if applicable, and to not seek or accept

additional payment from any Enrollee for any covered service; provided, however, that nothing in this Agreement shall prevent the MCO from seeking coordination of benefits or subrogation recoveries in accordance with applicable rules and regulations.

L. To make payment to health care providers for items and services which are subject to this Agreement and that are furnished to the Enrollees on a timely basis consistent with the claims payment procedures described in section §1902(a)(37)(A) of the Social Security Act, and Maryland Annotated Code, Health-General Article, §19-712.1, unless the health care provider and the MCO agree to an alternate payment schedule.

M. Not to hold Enrollees, the Department, or DHHS liable for the debts of the MCO or any of its subcapitated providers in the event of the MCO's insolvency or the insolvency of its subcapitated provider, but nothing in this paragraph shall waive the MCO's right to be paid for the services that it has provided to its members.

N. Not to hold Enrollees or DHHS liable for the debts of the MCO for services provided to the Enrollee:

a. in the event that the MCO fails to receive payment from the Department for such services, or

b. in the event that a health care provider with a contractual, referral, or other arrangement with the MCO fails to receive payment from the Department or the MCO for such services.

O. To submit to the Department within thirty (30) days of the date the MCO receives the monthly enrollment listings from the Department a list of persons who are known to the MCO to have disenrolled, relocated to a geographic area not serviced by the MCO, become ineligible to receive HealthChoice services from the MCO, or died.

P. To comply with all provisions of the Balanced Budget Act of 1997 that apply to this Agreement, including the State Medicaid Director's Letters regarding managed care issued or to be issued in the future. The following letters attached hereto have been issued to date and incorporated by reference:

Section	Subject	Date Issued
4704(a)	Emergency Services	02/20/98
	Emergency Services	05/06/98
	Post-Stabilization Care	08/05/98

Q. To inform its subcontractors of the provisions of the Social Security Act §1128 B attached hereto and incorporated by reference.

R. Not to knowingly have as a director, officer, partner, or owner of more than five percent (5%) of the entity's equity, a person who is or has been:

1. debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

2. an affiliate of a person described in (1) above.

S. To notify the Department, by facsimile and in accordance with Paragraph O of Section III of this Agreement within five (5) days of any change in its ownership in excess of five percent (5%).

T. Not to knowingly have an employment, consulting, or other agreement with a person described in Paragraph Q of this Section for the provision of items and services that are significant and material to the entity's obligations under this Agreement.

U. Notwithstanding any other provision of this Agreement, to be subject to any change in Federal or State law or regulation, or other policy guidance from HCFA or the Department that applies during the term of this Agreement. The Department shall provide at least 15 days notice of any policy changes and the MCO retains all rights available to challenge the authority or basis for any such changes.

V. To acknowledge the sanction provisions under 42 C.F.R. 434.67 and Part 1003.

W. Pursuant to 42 C.F.R. §417.479(a) and §422.208, not to make payment directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee.

X. To disclose to the Department the information on provider incentive plans listed in 42 C.F.R. §417.479(h)(1) and §417.479(I),and §422.210 at the times indicated in 42 C.F.R. §434.70 in order to determine whether the incentive plan(s) meets the requirements of 42 C.F.R. §417.479(d) - (g) and to provide the information on its physician incentive plans listed in 42 C.F.R. §417.479(h)(3) to any Enrollee, upon request.

Y. To execute the State Provider's Amendment to HealthChoice Provider Service Agreements contained in Appendix B of this Agreement at the same time that the MCO executes a HealthChoice Provider Service Agreement with a county health department.

II. THE DEPARTMENT AGREES:

A. To pay the MCO in accordance with COMAR 10.09.65.19.

B. If applicable, to pay accrued inpatient hospital charges once the Stop-Loss amount has been reached in accordance with COMAR 10.09.65.22 C, deducting ten percent (10%) of the amount paid by the Department to the hospital from the MCO's capitation payments, upon:

1. Confirmation of the MCO's eligibility for stop-loss protection for that Enrollee; and

2. Receipt by the Department of adequate documentation of the charges.

C. To produce and make available to the MCO on a monthly basis remittanc advice and the following reports:

1. MCO Capitation Detail Report;

2. MCO Capitation Summary Report;

3. MCO Capitation Report by Rate Group;

4. MCO Capitated Enrollment Report;

5. MCO Capitated Enrollment Summary;

6. MCO Dis-Enrollment Report By Site;

7. MCO Capitated Dis-Enrollment Summary; and

8. Zip Code Totals Within MCO Provider.

D. To include in the monthly enrollment listings sent to the MCO the adjustments provided by the MCO and accepted by the Department, and other appropriate debit and credit transactions.

III. THE DEPARTMENT AND THE MCO MUTUALLY AGREE:

A. That the term of this Agreement shall begin on January 1, 2000.

B. That this Agreement may be modified only in writing by the parties.

C. That the Department reserves the right to terminate this Agreement immediately upon receipt of:

1. Notification by DHHS that it is terminating Maryland's §1115 HealthChoice Waiver and funding thereunder; or

2. Notification by the Maryland Department of Budget and Management that State funds are not available for the continuation of HealthChoice.

D. That the Department may terminate this Agreement if the MCO fails to meet any one or more of the provisions of this Agreement or of applicable laws, rules, regulations, or guidelines effective as of the date of this Agreement or issued during the term of this Agreement, subject to the MCO's right to an opportunity to take corrective action pursuant to COMAR 10.09.73.01B prior to the imposition of a sanction.

E. That if the Department terminates this Agreement for any reason, it shall not be liable for any costs of the MCO associated with the termination, including but not limited to, any expenditures made by the MCO prior to the termination or related to implementing the termination; however, this does not relieve the Department of the obligation to make all payments to the MCO to which the MCO is entitled under the HealthChoice regulations.

F. That the MCO may appeal a termination of the Agreement by the Department in accordance with COMAR 10.09.72.06.

G. That the MCO has the right to terminate this Agreement upon ninety (90) days prior written notice to the Department.

H. That termination of this Agreement shall not discharge the obligations of the MCO with respect to services or items furnished prior to termination, including payment for covered services delivered during the contract period, retention of records and restitution to the Department of overpayments.

I. That in the event of the termination of the Agreement either by the Department or by the MCO, the MCO will furnish to the Department all information relating to the reimbursement of any outstanding claims for services rendered to its Enrollees, including those of its subcontractors, within forty-five (45) days of the effective date of termination.

J. That, with the exception of new Enrollees during the period of time between ten days after the Department's enrollment agent has notified the MCO of a new enrollment and receipt by the MCO of the Department's next regular monthly payment of capitation payment rates, the MCO is not required to pay for or provide services for any Enrollee for which it has not received a prepaid capitation rate from the Department.

K. That payments made under this Agreement will be denied for new Enrollees when, and for so long as, payments for those Enrollees are denied by HCFA under 42 C.F.R. §434.67(e), for violations of 42 C.F.R. §434.67 (a).

L. That this Agreement shall not be transferable or assignable.

M. That any change in Federal or State law or regulation that affects any provision or term of this Agreement shall automatically become a provision or term of this Agreement.

N. That they shall carry out their mutual obligations as herein provided in a manner prescribed by law and in accordance with all applicable regulations and policies as may from time to time be promulgated by DHHS or any other appropriate Federal or State agency, including compliance with the contract provisions or conditions required in all procurement contracts and subcontracts as specified under 45 C.F.R. Part 74.

O. That a notice required to be given to the other party under this Agreement, unless specified otherwise, is effective only if the notice is sent by first-class mail to the representative and address for that party listed below:

1. Notices to the Department shall be sent to:

   Ms. Jane Thompson
   Director of HealthChoice and Acute Care
   Department of Health and Mental Hygiene
   201 West Preston Street, 2nd Floor
   Baltimore, MD 21201

2. Notices to the MCO shall be sent to:

   _____

   _____

   _____

IN WITNESS WHEREOF, the parties hereto have hereunder executed this Agreement the day and year first above written.

FOR THE DEPARTMENT:

12/20/99
Date

Witness

Joseph M. Millstone, Director
Medical Care Policy
Maryland Department of Health
and Mental Hygiene

FOR THE MCO:

12/20/99
Date

Signature

Nancy Hall
Witness

Title

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

Assistant Attorney General

12/2/99
Date

APPENDIX A
MAXIMUM NUMBER OF RECIPIENTS
PERMITTED TO BE ENROLLED IN EACH LOCAL ACCESS AREA
IN THE MANAGED CARE ORGANIZATIONS'S APPROVED SERVICE AREA(S)

Name of Managed Care Organization: United HealthCare

Time Period: January 1, 2000 to December 31, 2000

Local Access Area	Maximum Number of Children Under 21	Maximum Number
Allegany	2,400	3,800
Anne Arundel North	9,600	29,200
Anne Arundel South	7,800	19,200
Baltimore City - SE/Dundalk	6,600	10,200
Baltimore City East	4,200	11,400
Baltimore City North Central	3,000	6,800
Baltimore City Northeast	1,200	4,000
Baltimore City Northwest	5,400	14,200
Baltimore City South	3,600	12,200
Baltimore City West	6,400	20,600
Baltimore County East	4,400	10,400
Baltimore County North	5,400	16,600
Baltimore County Northwest	3,400	12,800
Baltimore County Southwest	5,200	13,600
Calvert	800	1,400
Caroline	0	2,600
Carroll	2,500	6,700
Cecil	1,600	3,200
Charles	2,000	8,600
Dorchester	0	600
Frederick	2,400	4,200
Garrett		
Harford East	1,800	4,600
Harford West	3,600	10,600
Howard	4,400	18,800
Kent	200	400
Montgomery - Silver Spring	4,500	20,900
Montgomery Mid-County	2,600	9,200
Montgomery North	4,000	15,200
Prince George's Northeast	3,400	10,000
Prince George's Northwest	10,200	22,600
Prince George's Southeast	1,200	4,200
Prince George's Southwest	2,200	7,600
Queen Anne's	200	800
Somerset	600	600
St. Mary's	2,000	7,000
Talbot	600	1,200
Washington	1,800	3,400
Wicomico	1,000	2,600
Worcester	400	1,600

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HEALTHCHOICE AND ACUTE CARE ADMINISTRATION
MANAGED CARE ORGANIZATION

AMENDMENT TO CONTRACT AGREEMENT

This amendment is entered into this 1st day of April between the Maryland Department of Health and Mental Hygiene, hereafter referred to as "the Department", and United Health Care's Family First, a Maryland Corporation hereinafter referred to as "Managed Care Organization" (MCO).

WHEREAS, the Department and the MCO entered into a contract agreement for a term beginning January 1, 2000.

WHEREAS, the parties desire to amend the aforementioned contract effective on this 1st day of April .

NOW THEREFORE, the parties agree to amend the contract as follows:

Page 6 of 8, item C. and C.1 to read as specified:

C. That the Department reserves the right to terminate this Agreement immediately upon:
   1. Completion of this Section 1115 Research and Demonstration Waiver and Federal funding thereunder; or

IN WITNESS WHEREOF, the parties have executed this contract amendment the day and date first written above. This contract amendment is hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

Dated: 4/3/00

Witness: _____

_____
Joseph M. Millstone, Executive Director
Office of Health Services

Dated: 4/4/00

Witness: _____

_____

Title: COO Wellstar Health System of the MCO

APPROVED AS TO FORM AND LEGAL SUFFICIENCY:

this 15th day of March 2000

_____
Assistant Attorney General

MARYLAND MEDICAID

DENTAL FEE SCHEDULE AND PROCEDURE CODES

CDT-5

MARYLAND MEDICAL ASSISTANCE PROGRAM
DENTAL PROCEDURE CODES AND FEE SCHEDULE

CODE	BRIEF DESCRIPTION	MAX FEE		
D0485	CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL SUPPLIED BY REFERRING SOURCE	BR*		
D0502	OTHER ORAL PATHOLOGY PROCEDURES	BR		
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE	BR		
D0481	ELECTRON MICROSCOPY- DIAGNOSTIC	BR		
D0483	INDIRECT IMMUNOFLUORESCENCE	BR		
D0484	CONSULTATION ON SLIDES PREPARED ELSEWHERE	BR*		
D0485	CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL SUPPLIED BY REFERRING SOURCE	BR*		
D0502	OTHER ORAL PATHOLOGY PROCEDURES	BR		
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE BR	BR		
D1000-D1550 PREVENTIVE CARE				
DENTAL PROPHYLAXIS				
D1110	PROPHYLAXIS ADULT	36		
D1120	PROPHYLAXIS CHILD	24		
TOPICAL FLU RIDE TREATMENT (OFFICE PROCEDURE)				
D1201	TOPICAL APPLICATION OF FLUORIDE (INCLUDING	35		
	PROPHYLAXIS) - CHILD - THROUGH AGE 13			
D1203	TOPICAL APPLICATION OF FLUORIDE (EXCLUDING	14		
	PROPHYLAXIS) - CHILD - THROUGH AGE 13			
D1204	TOPICAL APPLICATION OF FLUORIDE (EXCLUDING	14		
	PROPHY) - ADULT - AGES 14 - 20			
D1205	TOPICAL APPLICATION OF FLUORIDE (INCLUDING	50		
	PROPHYLAXIS) - ADULT - AGES 14 - 20			
OTHER PREVENTIVE SERVICES				
D1310	NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE	0		
D1320	TOBACCO COUNSELING	0		
D1330	ORAL HYGIENE INSTRUCTION	0		
D1351	SEALANTS, PER TOOTH (Covered only for the occusal surfaces of	9		
	posterior permanent teeth without restorations or decay)			
SPACE MANAGEMENT THERAPY				
D1510	SPACE MAINTAINER-FIXED-UNILATERAL	84		
D1515	SPACE MAINTAINER-FIXED-BILATERAL	144		
D1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL	64		
D1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	96		
D1550	RECEMENTATION OF SPACE MAINTAINER	24		
D2000-D2999 III RESTORATIVE				
AMALGAM RESTORATIONS (INCLUDING POLISHING)				
D2140	AMALGAM 1 SURFACE, PRIMARY OR PERMANENT	70		
D2150	AMALGAM 2 SURFACES, PRIMARY OR PERMANENT	88		
D2160	AMALGAM 3 SURFACES, PRIMARY OR PERMANENT	104		
D2161	AMALGAM 4 OR MORE SURFACES, PRIMARY OR PERMANENT	58		
RESIN-BASED COMPOSITE RESTORATIONS-DIRECT				
D2330	RESIN 1 SURFACE, ANT.	84		
D2331	RESIN 2 SURFACES, ANT.	102		
D2332	RESIN 3 SURFACES, ANT.	125		
D2335	RESIN 4 OR MORE SURFACES OR INCISAL ANGLE	151		
D2388	RESIN-BASED COMPOSITE FOUR OR MORE SURFACES,	0		
	POSTERIOR PERMANENT			
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	75		
D2391	RESIN-BASED COMPOSITE- ONE SURFACE POSTERIOR	93		
D2392	RESIN-BASED COMPOSITE- TWO SURFACES, POSTERIOR	120		
D2393	RESIN-BASED COMPOSITE- THREE SURFACES, POSTERIOR	150		
D2394	RESIN-BASED COMPOSITE- FOUR OR MORE SURFACES, POSTERIOR	58		

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MARYLAND MEDICAL ASSISTANCE PROGRAM
DENTAL PROCEDURE CODES AND FEE SCHEDULE

CODE	BRIEF DESCRIPTION	MAX FEE		
D2955	POST REMOVAL (NOT IN CONJUNCTION W/ENDO.THERAPY)	BR		
D2957	EACH ADDITIONAL PREFABRICATED POST-SAME TOOTH	0		
D2960	LABIAL VENEER (LAMINATE) - BONDING	81		
D2961	LABIAL VENEER (RESIN LAMINATE) - LAB	81	PA	
D2962	LABIAL VENEER (PORCELAIN LAMINATE) - LAB	108	PA	
D2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK	BR		
D2975	COPING	BR		
D2980	CROWN REPAIR	BR		
D2999	UNSPECIFIED RESTORATIVE PROCEDURE	BR		
D3110-D3999 ENDODONTICS				
PULP CAPPIN				
D3110	PULP CAP DIRECT (EXCLUDING FINAL RESTORATION)	15		
D3120	PULP CAP INDIRECT (EXCLUDING FINAL RESTORATION)	15		
D3220	THERAPEUTIC PULPOTOMY(EXCLUDING FINAL RESTORATION)	60		
D3221	PULPAL DEBRIDEMENT, PRIMARY AND PERMANT TEETH	0		
	(pulpal debridement for the relief of acute pain prior to conventional			
	root canal therapy) (not to be used by provider completing endodontic treatment)			
PULPAL THERAPY				
D3230	PULPAL THERAPY - ANTERIOR-PRIMARY TOOTH	96	PA	
D3240	PULPAL THERAPY - POSTERIOR-PRIMARY TOOTH	115	PA	
ROOT THERAPY				
NOTE:	**REIMBURSEMENT FOR ROOT CANAL THERAPY INCLUDES ALL**			
	DIAGNOSTIC TESTS, PREOPERATIVE AND POSTOPERATIVE			
	RADIOGRAPHS, PREOPERATIVE AND POSTOPERATIVE TREATMENTS			
	TREATMENTS, PULPOTOMY AND PULPECTOMY.			
D3310	ENDODONTICS 1 CANAL	230	PA	
D3320	ENDODONTICS 2 CANALS	280	PA	
D3330	ENDODONTICS 3 CANALS	325	PA	
D3331	TREATMENT OF ROOT CANAL OBSTR NON-SURG	0		
D3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH	0		
D3333	INTERNAL ROOT REPAIR OF PERF DEFECTS	0		
	ENDODONTIC THERAPY ON PRIMARY TEETH			
*D3346	RETREATMENT OF PRIOR ROOT CANAL- ANTERIOR	230	PA	
*D3347	RETREATMENT OF PRIOR ROOT CANAL - BICUSPID	280	PA	
*D3348	RETREATMENT OF PRIOR ROOT CANAL- MOLAR	325	PA	
	*Not covered when service is provided by same			
	provider or associate within 2 years			
D3351	APEXIFICATION/RECALCIFICATION INITIAL VISIT	108		
D3352	APEXIFICATION/RECALCIFICATION INTERIM MEDS	67		
D3353	APEXIFICATION/RECALCIFICATION FINAL VISIT	67		
APICOECTOMY/PERIRADICULAR SERVICES				
D3410	SURGERY - ANTERIOR	108	PA	
D3421	SURGERY - BICUSPID	118	PA	
D3425	SURGERY - MOLAR	128	PA	
D3426	SURGERY EACH ADDITIONAL ROOT	81	PA	
D3430	RETROGRADE FILLING PER ROOT	24	PA	
D3450	ROOT AMPUTATION PER ROOT	81	PA	
D3460	ENDODONTIC ENDOSSEOUS IMPLANTS	0		
D3470	INTENTIONAL REIMPLANTATION (INCLUDES SPLINTING)	BR		

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MARYLAND MEDICAL ASSISTANCE PROGRAM
DENTAL PROCEDURE CODES AND FEE SCHEDULE

CODE	BRIEF DESCRIPTION	MAX FEE		
D5110-D5899 PROSTHODONTICS (REMOVABLE)				
COMPLETE DENTURES (includes routine post-delivery care)				
D5110	COMPLETE- MAXILLARY	375	PA	
D5120	COMPLETE- MANDIBULAR	375	PA	
D5130	IMMEDIATE- MAXILLARY	0		
D5140	IMMEDIATE- MANDIBULAR	0		
PARTIAL DENTURES (incl.routine post-delivery care) (3 or more teeth excluding third molars) (includes conventional clasps, rests, and teeth)				
D5211	MAXILLARY - RESIN BASE	225	PA	
D5212	MANDIBULAR - RESIN BASE	225	PA	
D5213	MAXILLARY - CAST METAL W/RESIN BASE	0		
D5214	MANDIBULAR - CAST METAL W/RESIN BASE	0		
D5225	MAXILLARY PARTIAL DENTURE-FLEXIBLE BASE (including any clasps, rests and teeth)	275		
D5226	MANDIBULAR PARTIAL DENTURE-FLEXIBLE BASE (including any clasps, rests and teeth)	275		
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE 1 PIECE CHROME	0		
	CASTING, CLASP ATTACHMENTS, PER UNIT INCL.PONTICS			
ADJUSTMENTS				
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	20		
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	20		
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	20		
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	20		
REPAIRS-Complete Dentures				
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	40		
D5520	REPLACE MISSING OR BROKEN TEETH (Each tooth)	20		
REPAIRS-Partials				
D5610	REPAIR RESIN DENTURE BASE	63(per denture)		
D5620	REPAIR CAST FRAMEWORK	BR		
D5630	REPAIR OR REPLACE BROKEN CLASP	63	PA	
D5640	REPLACE BROKEN TOOTH ON DENT NO OTHER REPAIR	20		
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	57	PA	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	65	PA	
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	0		
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	0		
REBASING				
NOTE:	**CONSIDERED AFTERCARE WITHIN THE FIRST SIX (6) MONTHS FOLLOWING DENTURE PLACEMENT AND IS NOT REIMBURSABLE. CANNOT BE PROVIDED MORE FREQUENTLY THAN ONCE EVERY TWO (2) YEARS.**			
D5710	COMPLETE MAXILLARY DENTURE (LAB)	BR		
D5711	COMPLETE MANDIBULAR DENTURE (LAB)	BR		
D5720	MAXILLARY PARTIAL DENTURE (LAB)	BR		
D5721	MANDIBULAR PARTIAL DENTURE (LAB)	BR		
RELINING				
D5730	COMPLETE MAXILLARY DENTURE (CHAIR)	0		
D5731	COMPLETE MANDIBULAR DENTURE (CHAIR)	0		
D5740	MAXILLARY PARTIAL DENTURE (CHAIR)	0		

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MARYLAND MEDICAL ASSISTANCE PROGRAM
DENTAL PROCEDURE CODES AND FEE SCHEDULE

CODE	BRIEF DESCRIPTION	MAX FEE		
D6010-D6199 IMPLANT SERVICES				
ENDOSTEAL				
D6010	ENDOSTEAL IMPLANT, SURGICAL PLACEMENT	BR		
EPOSTEAL				
D6040	EPOSTEAL IMPLANT, SURGICAL PLACEMENT	BR		
TRANSOSTEAL				
D6050	TRANSOSTEAL IMPLANT, SURGICAL PLACEMENT	BR		
D6053	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH	0		
D6054	IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH	0		
D6055	IMPLANT CONNECTING BAR	BR		
D6056	PREFABRICATED ABUTMENT-includes placement	0		
D6057	CUSTOM ABUTMENT- Includes placement	0		
D6058	ABUTMENT POCELAIN/CERAMIC CROWN	0		
D6059	ABUTMENT POCELAIN FUSED CROWN (HIGH)	0		
D6060	ABUTMENT PORCELAIN FUSED CROWN (BASE)	0		
D6061	ABUTMENT PORCELAIN FUSED CROWN (NOBLE)	0		
D6062	ABUTMENT CAST CROWN (HIGH)	0		
D6063	ABUTMENT CAST CROWN (BASE)	0		
D6064	ABUTMENT CAST CROWN (NOBLE)	0		
D6065	IMPLANT PORCELAIN/CERAMIC CROWN	0		
D6066	IMPLANT PORCELAIN FUSED CROWN (TITANIUM)	0		
D6067	IMPLANT METAL CROWN (TITANIUM)	0		
D6068	ABUTMENT RETAINER - CERAMIC/PORCELAIN FPD	0		
D6069	ABUTMENT RETAINER - PORCELAIN FUSED FPD (HIGH)	0		
D6070	ABUTMENT RETAINER - PORCELAIN FUSED FPD (BASE)	0		
D6071	ABUTMENT RETAINER - PORCELAIN FUSED FPD (NOBLE)	0		
D6072	ABUTMENT RETAINER - CAST METAL FPD (HIGH)	0		
D6073	ABUTMENT RETAINER - CAST METAL FPD (BASE)	0		
D6074	ABUTMENT RETAINER - CAST METAL FPD (NOBLE)	0		
D6075	IMPLANT RETAINER FOR CERAMIC FPD	0		
D6076	IMPLANT RETAINER - PORCELAIN FPD (TITANIUM/HIGH)	0		
D6077	IMPLANT RETAINER - CAST FPD (TITANIUM/HIGH)	0		
D6078	IMPLANT/ABUTMENT FIXED FOR COMPLETE-EDENT ARCH	0		
D6079	IMPLANT/ABUTMENT FIXED FOR PARTIAL-EDENT ARCH	0		
D6080	IMPLANT MAINTENANCE	BR		
D6090	IMPLANT REPAIR (PROSTHESIS)	BR		
D6094	ABUTMENT SUPPORTED CROWN	BR		
D6095	IMPLANT REPAIR (ABUTMENT)	BR		
D6100	IMPLANT REMOVAL	BR		
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	BR		
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD- (TITANIUM)	0		
D6199	UNSPECIFIED IMPLANT PROCEDURE	BR		
D6200-D6999 PROSTHODONTICS, FIXED				
FIXED PARTIAL DENTURE PONTICS (FIXED BRIDGES)				
D6205	PONTIC - INDIRECT RESIN BASED COMPOSITE	0		
D6210	HIGH NOBLE METAL CAST	0		
D6211	PREDOMINANTLY BASE METAL CAST	0		
D6212	NOBLE METAL CAST	0		
D6214	PONTIC-TITANIUM	0		
D6240	PORCELAIN FUSED TO HIGH NOBLE METAL	0		
D6241	PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0		
D6242	PORCELAIN FUSED TO NOBLE METAL	0		
D6245	PONTIC - PORCELAIN/CERAMIC	0		

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DENTAL PROCEDURE CODES AND FEE SCHEDULE

CODE	BRIEF DESCRIPTION	MAX FEE
D6975	COPING METAL	0
D6976	EACH ADDITIONAL CAST POST-SAME TOOTH	0
D6977	EACH ADDITIONAL PREFABRICATED POST-SAME TOOTH	0
D6980	FIXED PARTIAL DENTURE (FIXED BRIDGE) REPAIR BR	0
D6985	PEDIATRIC PARTIAL DENTURE, FIXED	0
D6999	UNSPECIFIED FIXED PROSTHETIC PROCEDURE	BR
D7110-D7999 ORAL SURGERY		
EXTRACTIONS		
NOTE:	**PREAUTHORIZATION IS REQUIRED FOR MULTIPLE EXTRACTIONS**	
	IN HOSPITALS (OTHER THAN EMERGENCY CONDITIONS) AND FOR	
	EXTRACTIONS REQUIRING REPLACEMENTS.	
D7111	EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH	27
D7140	EXTRACTION, ERUPTED TOOTH OR EXSPOSED ROOT (evation and/or	42
	removal)	
SURGICAL EXTRACTIONS		
D7210	SURGICAL REMOVAL ERUPTED TOOTH, REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH)	0
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	64
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	90
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	100
D7241	REMOVAL OF IMPACTED TOOTH, BONY, UNUSUAL	0
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING)	52 (complete)
OTHER		
D7260	OROANTRAL FISTULA CLOSURE	125 BR
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	55
D7270	TOOTH REIMPLANTATION/STABILIZATION	64
D7272	TOOTH TRANSPLANTATION	27
D7280	SURGICAL ACCESS OF UNERUPTED TOOTH	BR
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID	BR
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	BR
D7285	BIOPSY ORAL TISSUE-HARD (BONE, TOOTH)	BR
D7286	BIOPSY ORAL TISSUE SOFT	BR
D7287	EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION	39
D7288	BRUSH BIOPSY-TRANSEPITHELIAL SAMPLE COLLECTION	39
D7290	SURGICAL REPOSITIONING OF TEETH	BR
D7291	TRANSSEPTAL FIBEROTOMY	BR
ALVEOLOPLASTY		
D7310	ALVEOLOPLASTY WITH EXTRACTIONS-PER QUAD- NCSP	0
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS- ONE TO THREE TEETH OR TOOTH SPACES, PER QUAD	0
D7320	ALVEOLOPLASTY NO EXTRACTIONS - PER QUAD	48
D7321	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUAD	BR
VESTIBULOPLASTY		
D7340	RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	BR
D7350	RIDGE EXTENSION (INCLUDES GRAFTS, MUSCLE	BR
	REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT	
	AND MNGMT OF HYPER-TROPHIED/PLASTIC TISSUE	

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CODE	BRIEF DESCRIPTION	MAX FEE		
D7760	MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION	172 CPT		
D7770	ALVEOLUS - STABILIZATION OF TEETH, OPEN REDUCTION,	106 CPT		
	SPLINTING - REQUIRING SURGICAL INCISION			
D7771	ALVEOLUS - CLOSED REDUCTION, STABILIZATION OF TEETH	BR		
D7780	FACIAL BONES COMPLICATED REDUCTION	BR		
TEMPOROMANDIBULAR JOINT DYSFUNCTIONS				
D7810	OPEN REDUCTION OF DISLOCATION - SURGICAL EXPOSURE	158 CPT		
D7820	CLOSED REDUCTION OF DISLOCATION	27 CPT		
D7830	MANIPULATION UNDER ANESTHESIA	32 CPT		
D7840	CONDYLECTOMY	180 CPT	PA	
D7850	SURGICAL DISECTOMY,WITH/WITHOUT IMPLANT	276 CPT	PA	
D7852	DISC REPAIR	BR		
D7854	SYNOVECTOMY	BR		
D7856	MYOTOMY	BR		
D7858	JOINT RECONSTRUCTION	BR		
D7860	ARTHROTOMY	179 CPT	PA	
D7865	ARTHROPLASTY	306 CPT	PA	
D7870	ARTHROCENTESIS	17 CPT	PA	
D7871	NON-ARTHROSCOPIC LYSIS AND LAVAGE	0		
D7872	ARTHROSCOPY: DIAGNOSIS W/WITHOUT BIOPSY	172 CPT	PA	
D7873	ARTHROSCOPY: LAVAGE AND LYSIS OF ADHESIONS	143 CPT		
D7874	ARTHROSCOPY: DISC REPOSITIONING AND STABILIZE.	143 CPT		
D7875	ARTHROSCOPY: SYNOVECTOMY	143 CPT		
D7876	ARTHROSCOPY: DISCECTOMY	143 CPT		
D7877	ARTHROSCOPY: DEBRIDEMENT	143 CPT		
D7880	OCCLUSAL ORTHOTIC DEVICE	BR		
D7899	UNSPECIFIED TMD THERAPY	BR		
TRAUMATIC WOUNDS/TMD REPAIR				
D7910	SUTURE RECENT SMALL WOUNDS UP TO 5 CM	18 CPT		
D7911	COMPLICATED SUTURE UP TO 5 CM	27 CPT		
D7912	COMPLICATED SUTURE OVER 5 CM	BR		
OTHER REPAIRS				
D7920	SKIN GRAFTS (INCLUDE DEFECT,LOCATION&GRAFT TYPE)	BR		
D7940	OSTEOPLASTY (FOR ORTHOGNATHIC DEFORMITIES)	BR		
D7941	OSTEOTOMY MANDIBULAR RAMI	BR		
D7943	OSTEOTOMY RAMI WITH BONE GRAFT	BR		
D7944	OSTEOTOMY SEGMENTED/SUBAPICAL-PER	BR		
	SEXTANT OR QUAD	BR		
D7945	OSTEOTOMY BODY OF MANDIBLE	BR		
D7946	LEFORT I-TOTAL MAXILLA ((OSTEOTOMY)	BR		
D7947	LEFORT I-SEGMENTED MAXILLA (OSTEOTOMY)	BR		
D7948	LEFORT II OR III, NO GRAFT (OSTEOPLASTY)	BR		
D7949	LEFORT II OR III WITH GRAFT	BR		
D7950	OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES- AUTOGENOUS, BY REPORT	BR		
D7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION- PER SITE	BR		
D7955	REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT	BR		
D7960	FRENULECTOMY-SEPARATE PROCEDURE (FRENECTOMY;	63		
	FRENOTOMY)			
D7963	FRENULOPLASTY	BR		
D7970	EXCISION HYPERPLASTIC TISSUE PER ARCH	27		
D7971	EXCISION OF PERICORONAL GINGIVA	25		
D7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	42		
D7980	SIALOLITHOTOMY	18 CPT		
D7981	EXCISION SALIVARY GLAND	106 CPT		
D7982	SIALODOCHOPLASTY	133 CPT	PA	

Descriptions of Abbreviations:
BR - By Report
PA - Preauthorization required
D - Deleted code
NCSP - Not covered as a separate procedure
0 - Not covered by Maryland Medicaid

MARYLAND MEDICAL ASSISTANCE PROGRAM
DENTAL PROCEDURE CODES AND FEE SCHEDULE

CODE	BRIEF DESCRIPTION	MAX FEE		
CONSULTATION				
D9310	CONSULTATION -(DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN PRACTITIONER PROVIDING TREATMENT	48		
VISITS				
D9410	HOUSE CALLS	15		
D9420	HOSPITAL CALLS	15		
D9430	OFFICE VISIT (REGULAR HOURS)	NCSP		
D9440	OFFICE VISIT (AFTER REGULAR HOURS)	0		
D9450	CASE PRESENTATION, DETAILED AND EXTENSIVE TREATMENT PLANNING	0		
DRUGS				
D9610	THERAPEUTIC DRUG INJECTION	BR		
D9630	OTHER DRUGS	1.00 BR		
OTHER				
D9910	APPLY DESENSITIZING MEDICATION	10		
D9911	APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH	0		
D9920	BEHAVIOR MANAGEMENT	0		
D9930	TREATMENT OF COMPLICATIONS (POST-SURGICAL) NON-ROUTINE	BR		
D9940	OCCLUSAL GUARD	BR		
D9941	FABRICATION OF ATHLETIC MOUTH GUARD	40		
D9942	REPAIR AND/OR RELINE OF OCCLUSAL GUARD	BR		
D9950	OCCLUSION ANALYSIS - MOUNTED CASE	0		
D9951	OCCLUSAL ADJUSTMENT - LIMITED	33		
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	66		
D9970	ENAMEL MICROABRASION	0		
D9971	ODONTOPLASTY 1-2 TEETH; INCLUDES REMOVAL OF ENAMEL PROJECTIONS	0		
D9972	EXTERNAL BLEACHING-PER ARCH	0		
D9973	EXTERNAL BLEACHING-PER TOOTH	0		
D9974	INTERNAL BLEACHING-PER TOOTH	0		
D9999	UNSPECIFIED DENTAL TREATMENT	BR		
	* For CDT codes D0484 and D0485, if the consultant assumes responsibility for the care of the patient, the service that was rendered by the consultant is not considered a consultation and is not a reimbursable service.			

Descriptions of Abbreviations:
BR - By Report
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10.09.65.19

.19 MCO Reimbursement.

A. Generally.

(1) Payment to an MCO for each enrollee shall be at a fixed capitation rate, as specified in §B(4) of this regulation.

(2) An MCO shall be reimbursed at rates set forth in this regulation only for individuals enrolled under the Maryland Medicaid Managed Care Program.

(3) The capitation rate paid to an MCO by the Department shall be accepted as payment in full for all benefits provided by the MCO.

(4) The Department has the authority to recover any overpayments made to MCOs.

(5) An MCO shall conform to the Department's computer coding requirements.

(6) A capitation payment may not be made to an MCO on behalf of an enrollee for whom capitation payment for the same period has been made to any other MCO having an agreement with the Department.

(7) Effective January 1, 2005, the Department may consider a retroactive capitation payment to an MCO, if the MCO notifies the Department within 9 months of the first missed capitation payment for an enrollee for whom the MCO has not received all appropriate capitation payments.

B. Capitation Rate-Setting Methodology.

(1) Families and Children. Capitation rates for enrollees who are waiver-eligible based upon receipt of benefits through TCA or programs for medically needy families and children, including SOBRA children and Maryland Children's Health Program (MCHP), shall be established as follows:

(a) For enrollees eligible under COMAR 10.09.63.01A(1) or (3), and for children eligible under COMAR 10.09.63.01A(2) for whom the Department has sufficient clinical data, the Department shall:

(i) Determine an adjusted clinical group (ACG) assignment utilizing an enrollee's past diagnostic record;

(ii) Utilizing aggregated enrollee ACG data, on an annual basis define a limited number of risk adjustment categories that reflect levels of relatively homogenous resource utilization by ACG assignment; and

(iii) Assign an enrollee to a risk adjustment category based upon the enrollee's ACG assignment;

(b) Except as provided in §B(1)(c) of this regulation, for enrollees for whom the Department has insufficient data to generate an ACG assignment, the Department shall assign the enrollee to a risk adjustment category that reflects the enrollee's:

(i) Age, residence, and gender; and

(ii) Birth weight with respect to an enrollee born after December 31, 2004; and

(c) On the basis of the enrollee's residence, the Department shall assign:

(i) All SOBRA mothers enrolled pursuant to COMAR 10.09.63.01A(2) to one of the two "SOBRA mother" payment categories set forth in §B(4)(a) of this regulation; and

(ii) Enrollees with HIV to one of the two HIV payment categories set forth in §B(4)(a) of this regulation.

(2) Disabled. Capitation rates for enrollees who are waiver-eligible based upon receipt of benefits through SSI or as medically needy, aged, blind, or disabled shall be established as follows:

(a) Except as provided in §B(2)(c) of this regulation, for enrollees for whom the Department has sufficient clinical data, the

Department shall:

(i) Determine an adjusted clinical group (ACG) assignment utilizing an enrollee's diagnostic record;

(ii) Utilizing aggregated enrollee ACG data, on an annual basis define a limited number of risk adjustment categories that reflect levels of nearly homogenous resource utilization by ACG assignment; and

(iii) Assign an enrollee to a risk adjustment category (RAC) based upon the enrollee's ACG assignment; and

(b) Except as provided in §B(2)(c) of this regulation, for enrollees for whom the Department has insufficient data to generate an ACG assignment, the Department shall assign the enrollee to a risk adjustment category that reflects the enrollee's age, residence, and gender; and

(c) On the basis of the enrollee's residence, the Department shall assign:

(i) Enrollees with HIV to one of the two HIV payment categories set forth in §B(4)(b) of this regulation; and

(ii) Enrollees with AIDS to one of the two AIDS payment categories set forth in §B(4)(b) of this regulation.

(3) Rate Setting Methodology for Supplemental Delivery/Newborn Payments. In addition to the monthly payment specified in §B(4)(a) or (b) of this regulation for an enrollee's payment category the Department shall pay an MCO one supplemental payment per pregnancy in the amount specified in §B(4)(c) of this regulation, upon delivery of one or more live infants without regard to method, timing, or place of delivery.

(4) Except in the extent of adjustments required by §D of this regulation, or by Regulations .19-1—.19-4 of this chapter, the Department shall make payments monthly at the rates specified in the following tables:

(a) Rate Table for Families and Children

Effective January 1, 2007—December 31, 2007

Demographic Cells	Age	Gender	PMPM Baltimore City	PMPM Rest of State
	Under age 1 Birth Weight 1500 grams or less	Both	$ 6,007.93	$ 5,926.16
	Under age 1 Birth Weight over 1500 grams	Both	$ 382.85	$ 289.03
	1—5	Male	$ 183.06	$ 148.62
		Female	$ 156.05	$ 126.69
	6—14	Male	$ 105.27	$ #032; 85.47
		Female	$ #032; 93.68	$ #032; 76.06
	15—20	Male	$ 130.95	$ 106.31
		Female	$ 207.05	$ 168.10
	21—44	Male	$ 360.77	$ 292.90
		Female	$ 379.81	$ 308.36
	45—64	Male	$ 964.09	$ 782.72
		Female	$ 820.32	$ 665.99

ACG—adjusted cells				
ACG 100, 200, 300, 500, 600, 1100, 1600, 2000, 2400, 3400, 5110, 5200	RAC1	Both	$ #032; 95.59	$ #032; 84.06
ACG 400, 700, 900, 1000, 1200, 1300, 1710, 1800, 1900, 2100, 2200, 2300, 2800, 2900, 3000, 3100, 5310	RAC2	Both	$ 113.92	$ 100.18
ACG 1720, 1730, 2500, 3200, 3300, 3500, 3800, 4210, 5230, 5339	RAC3	Both	$ 144.13	$ 126.75
ACG 800, 1740, 1750, 2700, 3600, 3700, 3900, 4000, 4100, 4220, 4310, 4410, 4510, 4610, 4710, 4720, 4810, 5340	RAC4	Both	$ 237.86	$ 209.17
ACG 1400, 1500, 1750, 1770, 2600, 4320, 4520, 4620, 4820	RAC5	Both	$ 335.35	$ 294.89
ACG 4330, 4420, 4830, 4910, 4920, 5010, 5020, 5040	RAC6	Both	$ 524.43	$ 461.17
ACG 4430, 4730, 4930, 5030, 5050	RAC7	Both	$ 738.62	$ 649.52
ACG 4940, 5060	RAC8	Both	$ 1,166.22	$ 1,025.54
ACG 5070	RAC9	Both	$ 1,563.27	$ 1,374.70
SOBRA Mothers			$ 706.00	$ 573.18
Persons with HIV	All	Both	$ 847.43	$ 847.43

(b) Rate Table for Disabled Individuals

Effective January 1, 2007—December 31, 2007

Demographic Cells	Age	Gender	PMPM Baltimore City	PMPM Rest of State
	Under Age 1	Both	$ 2,265.48	$ 2,265.48
	1—5	Male	$ 764.90	$ 764.90
		Female	$ 873.33	$ 873.33
	6—14	Male	$ 176.34	$ 176.34
		Female	$ 266.92	$ 266.92
	15—20	Male	$ 391.73	$ 391.73
		Female	$ 438.80	$ 438.80
	21—44	Male	$ 1,292.65	$ 1,049.46
		Female	$ 1,219.14	$ 989.78
	45—64	Male	$ 1,733.23	$ 1,407.15
		Female	$ 1,645.35	$ 1,335.81
ACG—adjusted cells				
ACG 100, 200, 300, 1100, 1300, 1400, 1500, 1600, 1710, 1720, 1730, 1900, 2400, 2600, 2900, 3400, 5110, 5200, 5310	RAC10	Both	$ 248.19	$ 218.25

ACG 400, 500, 700, 900, 1000, 1200, 1740, 1750, 1800, 2000, 2100, 2200, 2300, 2500, 2700, 2800, 3000, 3100, 3200, 3300, 3500, 3900, 4000, 4310, 5330	RAC11	Both	$ 344.99	$ 303.38
ACG 600, 1760, 3600, 3700, 4100, 4320, 4410, 4710, 4810, 4820	RAC12	Both	$ 625.62	$ 550.16
ACG 3800, 4210, 4220, 4330, 4420, 4720, 4910, 5320	RAC13	Both	$ 723.11	$ 635.89
ACG 800, 4430, 4510, 4610, 5040, 5340	RAC14	Both	$ 970.50	$ 853.43
ACG 1770, 4520, 4620, 4830, 4920, 5050	RAC15	Both	$ 1,083.45	$ 952.76
ACG 4730, 4930, 5010	RAC16	Both	$ 1,411.05	$ 1,240.83
ACG 4940, 5020, 5060	RAC17	Both	$ 1,968.46	$ 1,731.01
ACG 5030, 5070	RAC 18	Both	$ 2,654.30	$ 2,334.12
Persons with AIDS	All	Both	$ 3,681.77	$ 3,477.78
Persons with HIV	All	Both	$ 2,071.04	$ 2,071.04

(c) Rate Table for Supplemental Payment for Delivery/Newborn

Effective January 1, 2007—December 31, 2007

Supplemental Payment Cells	Age/RAC	Gender	Baltimore City	Rest of State
Delivery/Newborn—live birth weight over 1,500 grams	All	Both	$12,618.96	$10,251.01
Delivery/Newborn—live birth weight 1,500 grams or less	All	Both	$82,185.64	$65,700.88

(d) Interpretation of Rate Table for Families and Children. The table found at §B(4)(a) of this regulation shows capitation rates for individuals who are:

(i) Waiver eligible based on receipt of benefits through TCA or programs for medically needy families and children;

(ii) SOBRA children;

(iii) SOBRA mothers; and

(iv) The Maryland Children's Health Program.

(e) Interpretation of Rate Table for Disabled Individuals. The table found at §B(4)(b) of this regulation shows the capitation rates for individuals who are waiver-eligible based upon receipt of benefits through SSI or as medically needy, aged, blind, or disabled.

(f) Interpretation of Rate Table for Supplemental Payment for Delivery/Newborn. The table found at §B(4)(c) of this regulation shows a supplemental payment made in connection with deliveries of MCO enrollees, regardless of the enrollee's payment category under COMAR 10.09.65.19B(4)(a) or (b).

(g) Interpretation of Rate Tables in §B(4) of this regulation. "PMPM" means the per member per month payment rate.

(5) Consistent with the terms set forth in Regulation .19-5 of this chapter, the Department may, in consultation with the Commissioner, adjust the capitation payment of an MCO if it determines that the MCO's loss ratio, not including any rebate received by the MCO is less than 85 percent.

C. The Department shall reimburse fee-for-service:

(1) The Departmental share for any enrollee participating in the Stop Loss Program pursuant to Regulation .22 of this chapter; and

(2) The cost of those services specified in COMAR 10.09.69.06—.13 provided to the participant that have been authorized

by the participant's case manager in accordance with the participant's plan of care.

D. Interim Rates Adjustments.

(1) Under the circumstances described in §D(2) and (3) of this regulation, the Department shall adjust the capitation rates set forth in §B(4)(a) and (b) of this regulation to reflect changes in service costs during the contract year due to an occurrence listed in §D(2) of this regulation.

(2) The Department shall adjust the payment rates specified in §B(4)(a)—(c) of this regulation to reflect service cost changes that qualify under §D(3) of this regulation and result from:

(a) An addition or deletion of services covered under the HealthChoice benefits package;

(b) An increase or decrease in Medicaid fee-for-service payment rates or copayments, if the MCOs are obligated to adjust their payment rates to providers as a result of those fee-for-service rate changes;

(c) An increase or decrease in statewide hospital charge-per-case as approved by the Health Services Cost Review Commission; or

(d) An increase or decrease in the statewide hospital outpatient rate update factor as approved by the Health Services Cost Review Commission.

(3) The Department shall make an interim rates adjustment if the effect of an occurrence listed in §D(2) of this regulation is sufficient to result in program-wide overpayment or underpayment of at least 0.2 percent because of the difference between:

(a) Service cost projections used to develop the rates set forth in §B(4)(a) and (b) of this regulation; and

(b) Service costs for the same period, taking into account an occurrence that is listed in §D(2) of this regulation.

(4) The Department shall make any interim rates adjustments required by this section in amounts that are proportionate to the overpayment or underpayments described in §D(3) of this regulation.

(5) Provider rate adjustments as specified in §D(2)(b) of this regulation may not require the MCOs to pay providers more than the Medicaid fee-for-service rate.

(6) The Department shall make supplemental payments to an MCO that reflect increases in MCO provider payments for trauma services described in COMAR 10.25.10.

(7) MCOs shall pay dental providers at least at the 50th percentile payment rate for the South Atlantic Region as reported by the American Dental Association for 2003 for the twelve procedure codes listed in the following table:

CDT-4 Procedure Code	Description	50th Percentile ADA Rate for South Atlantic Region for 2003
D2140	Amalgam-1surf	$70
D2150	Amalgam-2surf	$88
D2160	Amalgam-3surf	$104
D2330	Resin-1surf, ant	$84
D2331	Resin-2surf, ant	$102
D2332	Resin-3surf, ant	$125
D2335	Resin-4surf, incisal angle	$151
D2391	Resin-1 surf, post	$93
D2392	Resin-2 surf, post	$120

D2393	Resin-3 surf, post	$150
D2930	Prefab SSC-primary	$154
D2931	Prefab SSC-permanent	$180

(8) Notwithstanding §D(2) and (3) of this regulation, the Department may not make an adjustment to capitation rates for increases in restorative dental expenditures resulting from §D(7) of this regulation.

PROTECTING VULNERABLE CHILDREN WITH ACUTE CARE DENTAL NEEDS

The tragic death of 12-year old Deamonte Driver of Maryland who died from complications of an acut dental infection highlight a basic need within our health care system to identify individuals with acute dental needs and ensure that they obtain timely and necessary treatment.

Included in this document are:

- Section I: Four "concepts" for consideration that could provide an immediate first-step toward addressing some of the critical shortcomings that led to Deamonte's unnecessary death;
- Section II: Four statutory programs that, if amended, could advance priorities with regard to eliminating barriers to oral health care access for vulnerable populations; and
- Section III: A legislative proposal that would increase oral healthcare access for vulnerable populations.

SECTION I: FOUR "CONCEPTS" FOR IMMEDIATE IMPACT

1. Improving Access to Dental Services for At-Risk Children

Provide a Federal "dental disproportionate share" (DDS) payment to academic dental institutions (ADI) and other dental safety net providers that serve large numbers of underserved children who are at a higher risk for acute dental disease. Dental disproportionate share (DDS) providers would receive federal and state funds to stabilize the costs associated with providing dental services to disproportionate numbers of: indigent children; children who are eligible for Medicaid or the State Children's Health Insurance Program; and children who are uninsured. Federal matching funds would be combined with state funds to provide DDS payments to public and private academic and other safety-net dental clinics through a formula established by Congress. Based upon this formula, DDS payments would be made directly by states to individual academic dental clinics and other dental safety-net providers.

Rationale: The dental safety net serves only about seven percent of those in need of oral health care. Roughly 42 percent of community-based health centers have gaps in their capacity to provide comprehensive dental services. Academic dental institutions have access to state-of-the-art dental research and a history of serving vulnerable populations. In states with dental schools they are often the major dental safety-net provider. Academic dental clinics are best equipped to meet the needs of large numbers of underserved children whose dental care has been neglected and whose conditions as a result are often complex. DDS payments will ease the costly burden facing ADIs when Medicaid or SCHIP reimbursement rates are low and when they are not reimbursed at all for services to uninsured children.

2. Ensure Dental Safety-Net Funding Addresses Needs of At-Risk Children

Establish a demonstration program to identify successful models that assess and tr at und rserved children's acute dental needs. Provide Federal funding for a national demonstration program that would award grants to academic dental institutions, on a competitive basis, to develop nationally replicable models for identifying oral health needs and providing timely treatment to underserved children who are at a higher risk for acute dental disease. Outcomes data would be obtained with the goal of establishing "best practices" that

address this critical oral health care need. Best practices would be disseminated to other academic dental institutions and safety net providers receiving DDS funds.

Rationale: Academic dental institutions, because of their long history of care to the underserved, have developed many innovative methods for delivering dental care to underserved and low-income populations. A demonstration program would improve state and federal investments in dental programs by allowing ADIs to research, implement and disseminate the most successful preventive strategies, interventions and clinical approaches that address the etiology, pathogenesis, diagnosis, prevention, and treatment of pediatric oral, dental, craniofacial diseases and conditions.

3. Improve Oral Health & Prevent Rampant Dental Disease in At-Risk Childr n

Provide Federal funds to states for school-based oral health promotion, educati n and prevention programs. Provide Federal funding to States and Indian Tribes for the development and implementation of school-based oral health promotion and disease prevention programs. Federal matching funds would be used by states to provide payments to eligible elementary or secondary schools for the purpose of implementing oral health promotion and prevention strategies for children who are at a higher risk for acute dental disease. Eligible schools must be located within an area that is designated as dentally underserved or in rural or urban settings when 50 percent of students are eligible for Medicaid or SCHIP. Funds would be used to enable schools to provide children with basic education, prevention and emergency dental care by licensed dental professionals within their scope of practice.

Rationale: The Centers for Disease Control and Prevention (CDC) found that delivering sealants to all children attending low-income schools was the most cost-effective strategy in significantly reducing as child's risk of having untreated dental disease. Combining oral health promotion and education with prevention strategies will improve the oral health of children who are at a higher risk for dental disease. Almost as importantly, these program save money. Delta Dental, a private dental insurer estimates that preventive care, early detection, and treatment of oral health conditions save $4 billion annually in the U.S. According to the Children's Dental Health Project, dental costs for children who receive preventative dental care early in life are 40 percent lower than costs for children whose oral health is neglected. The American Dental Hygienists Association estimates that for every $1 spent on prevention in oral health care, $8 to $50 are saved on restorative and emergency dental procedures. Finally, the W.K. Kellogg Foundation reported that children who accessed dental care at a young age in Spokane, Washington could save the state an average of $113 per cavity averted per tooth. (For additional information on oral health promotion and disease prevention, see Attachment 1.)

4. The Deamonte Driver Dental Reimbursement Program (3DRP)

Enact "The Deamonte Driver Dental Reimbursement Program Act" (3DRP) within the HRSA Division of Medicine and Dentistry. The 3DRP program would award competitive grants to academic dental institutions and eligible community-based organizations in order to assist them in planning and delivering high-quality, comprehensive oral healthcare to homeless men, women, and children. Eligible academic dental institutions are dental schools, hospitals with postdoctoral dental education programs and dental hygiene programs. Eligible community-based organizations are those that partner with academic dental institutions in providing oral health care in community-based settings. Eligible community-based programs would be required to provide education and clinical training for dental care providers located in community-based settings.

SECTION II: AMENDMENTS TO STATUTORY PROGRAMS

1. State Children's Health Insurance Program (SCHIP)

An important step to improve access to dental care for vulnerable children under SCHIP would be to include in the upcoming reauthorization of the statute the following recommendations endorsed by the dental community:

- Establish a Federal guarantee for dental coverage in SCHIP
- Develop a dental wrap-around benefit in SCHIP
- Support ongoing outreach efforts to enroll all eligible children in SCHIP
- Enact mechanisms to ensure reliable data reporting on dental care in SCHIP.

2. Simplify and Streamline Medicaid Application, Enrollment, Recertification

Simplify and streamline the application, enrollment and recertification process for Medicaid. Doing so would help to expedite health coverage for the homeless. Many states have created enrollment barriers that disproportionately affect these populations, for example, lengthy and complex enrollment procedures; excessive documentation requirement; lack of accommodation for limited English proficiency, etc.

3. Dental Health Improvement Act

The Dental Health Improvement Act (DHIA), championed by Senators Susan Collins and Russ Feingold, provides state grants to improve and strengthen the dental workforce. During the reauthorization of the statue a new provision could be added to encourage the delivery of oral health care to homeless individuals and families.

DHIA's current provisions are:

- Recruitment and retention of dentists in geographic regions that have low access
- Grants, low-interest or no-interest loans to help dentists who participate in the Medicaid program to establish or expand practices in dental health professions shortage areas (D-HPSAs) by equipping dental offices or sharing in the overhead costs of such operations
- Recruitment and retention of faculty at dental schools whose missions include community outreach/service and have a record of serving the underserved
- Establishment or expansion of dental residency programs in coordination with accredited dental training facilities in states without dental schools and placement of residents
- Student loan repayment for dentists practicing in D-HPSAs who agree to provide dental care to patients regardless of ability to pay and offers on a sliding payment scale
- Expand or establish oral health services in D-HPSAs at school-linked dental facilities, dental school-based facilities, community-based dental facilities, free-standing dental clinics, consolidated health center dental facilities, and establish mobile or portable dental clinics and the practice of teledentistry
- Community-based prevention services (for example, water fluoridation, dental sealant programs)
- Development of a state dental officer position or the augmentation of a current State dental office to coordinate oral health and access issues in the state

4. Incr ase Acc for Native Am rican and Alaska Nativ Populations

Increase the Indian Health Service (IHS) loan repayment award size and make tax free the IHS Loan Repayment Program (LRP) and scholarship programs. These programs help recruit and retain dentists and dental hygienists into the IHS which increases access to oral health care by Native populations.

Increasing the IHSLRP from $24,000 to $25,000 annually for the first two years of service and up to $35,000 for a third year of service will permit the IHS to compete for students who choose National Health Service Corps (NHSC) over IHS. Equalizing the IHS and NHSC programs will enhance the IHS competitiveness for health care providers seeking loan repayment in exchange for service in eligible sites.

Because IHS loan repayments and scholarships are deemed taxable income, the IHS pays up to 20% of Federal taxes directly to the Internal Revenue Service (IRS). Making IHS awards tax free, just as NHSC scholarship and loan repayment awards are tax free, will enable IHS to devote scare funds to recruiting and retaining more health care providers.

5. Rural Health Clinics and Dental Care

Add preventive dental services to the list of core services that rural health clinics are required to provide on site or under arrangement. To improve the oral health status of rural America, prevention activities like adding fluoride to water, education, and regular professional prophylaxis are essential.

The delivery of health care in rural America is changing rapidly. In spite of this change, one thing remains constant: Rural communities across America rely on hospitals and health care providers provide care to all, including those who are uninsured or underinsured. Often, full-service community hospitals in rural areas are safety net providers, providing basic health service for those in need. Very often oral health care is unavailable in these settings.

SECTION III: LEGISLATION INTRODUCED 110th CONGRESS

1. The Children's Dental Health Improvement Act (S 739/HR 1781)

The Children's Dental Health Improvement Act (S. 739/H.R. 1781) was introduced in the Senate on March 1, 2007 by Jeff Bingaman and has six cosponsors including Senators Cardin and Mikulski as well as Cantwell, Cochran, Lincoln and Kerry. H.R. 1781 was introduced on March 29, 2007 by Rep. Dingell and has 17 cosponsors including Representatives Cummings, Hoyer and Wynn as well as Simpson, Allen, Capps, Davis, DeGette, Delahunt, Engel, Eshoo, Pallone, Ross, Schakowsky, Shea, Towns, and Waxman.

Attachm nt 1

ORAL HEALTH PROMOTION AND DISEASE PREVENTION

Tooth decay has declined dramatically among school-aged children due to preventive strategies such as community water fluoridation and the use of fluoride toothpastes. Despite these gains, tooth decay remains a significant problem with significant disparities noted for poor children and racial and ethnic groups. In the United States, 52 percent of children between the ages of 5 and 9 have had a cavity. Only 23 percent of all 8-year olds in the U.S. have at least one dental sealant, and only 3 percent of 8-year olds racial minorities living in poverty have a dental sealant. Dental sealants, a plastic coating placed in the pits and grooves of molar teeth, have been proven to prevent dental cavities on these chewing surfaces.

Studies carried out in the past 20 years provide strong evidence to support the effectiveness of sealants in preventing the development of caries in tooth pits and fissures. Economic analyses suggest that community sealant programs are cost-effective and may even provide cost savings when used in high-risk populations. Experts recommend that programs be limited to high-risk children and high-risk teeth.

One proven strategy for reaching low-income children who are at higher risk for dental disease is through school-based programs that support linkages with health care professionals and other dental partners in the community. The U.S. Task Force on Community Preventive Services reviewed the scientific evidence with regard to the effectiveness of school-based sealant programs and found a reduction in dental cavities of 60 percent. The Task Force issued a strong recommendation for school-based sealant delivery programs.

Community programs that provide sealants directly to schoolchildren generally target vulnerable populations less likely to receive private dental care, such as children eligible for free or reduced-cost lunch programs. School-based programs are usually conducted entirely on site. School-linked programs conduct some portion of the program in schools, such as patient selection and parental permission, but generally provide sealants at an off-site private practice or clinic.

Oral disease prevention and health promotion approaches, such as appropriate use of fluorides and dental sealants, highlight opportunities for community-based programs and practitioners as well as collaborations among health professionals. Many community-based programs require a combined effort among social service, health care, and education services at the local and state level. The public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups, and the integration of oral and general health programs is lacking.

There are exemplary oral health programs in Nevada, Rhode Island, South Carolina and Wisconsin. For example, the state of Nevada, with a cooperative agreement with the Centers for Disease Control and Prevention (CDC), has funded an oral health program infrastructure, including a state sealant program coordinator and state oral health program manager. In one effort the state has targeted dental sealant programs to schools in low-income areas. During the 2003-2004 school year, 3,677 sealants were provided for 1,211 second grade schoolchildren.

State oral health promotion and disease control programs could be considered for implementation at the federal level.

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A GUIDE TO CHILDREN'S DENTAL CARE IN MEDICAID

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In the early 1980's, the Centers for Medicare & Medicaid Services (CMS) (formally the Health Care Financing Administration, published "*A Guide to Dental Care: EPSDT/Medicaid.*" That Guide was intended to complement, supplement and expand upon policy information contained in CMS' State Medicaid Manual (SMM), which is available on the Internet at www.hcfa.gov/pubforms/pub45/pub_45.htm. The Guide was developed for the use of State Medicaid agencies, dental and other health care providers, and national, state and local policy makers involved in organizing and managing oral health care for children under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service. Now long out-of -print, photocopies of the original Guide continue to be requested frequently by individuals and organizations seeking information on children's oral health services and referred to the Guide by the SMM.

Deleted: (HCFA), hereafter referred to as the Centers for Medicare and Medicaid Services (CMS) to reflect administrative changes implemented in 2001.

Over the past two decades, however, dramatic changes have occurred in dental science and technology, in public policy approaches to dental care delivery, and in the Medicaid program itself. These changes have been of a magnitude such that much of the information in the original Guide no longer reflects the state-of-the-art of dental service delivery. In addition, CMS, in collaboration with state Medicaid agencies, had been developing initiatives aimed at addressing concerns about children's access to dental services in the Medicaid program. These concerns had been highlighted recently in two reports by the U. S. General Accounting Office and in the U. S. Surgeon General's report on oral health in the Nation. Substantial revision of the original Guide clearly was needed if it was to be of continued value to those seeking modern information about children's dental care in Medicaid.

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Consequently, CMS issued a contract to the American Academy of Pediatric Dentistry (AAPD) for the purpose of reviewing the original Guide and developing a revision for use by stakeholders concerned about children's oral health in Medicaid. The contractor was requested to incorporate information on the organization and financing of dental services, dental workforce and capacity, and accountability, along with other administrative issues which might be of assistance to state Medicaid agencies and stakeholders in their efforts to improve access to oral health services for children. In fulfillment of its contract, the AAPD developed a draft of the revised Guide, submitted the draft to wide review and comment by major national organizations concerned and knowledgeable about pediatric oral health, and produced the document provided here: "*A Guide to Children's Dental Care in Medicaid.*" The information in the revised Guide is based wherever possible on scientific evidence with appropriate citations provided, and on expert opinion where scientific evidence is inconclusive or not available.

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April 17, 2007

Ms. Susan Tucker
Executive Director
Office of Health Services
Department of Health and Mental Hygiene
201 West Preston St.
Baltimore, MD 21201

Dear Ms. Tucker:

Under Rule 8(a)(i) of the Rules of the Committee on Oversight and Government Reform, the Subcommittee on Domestic Policy has oversight jurisdiction over all domestic policies. In furtherance of this oversight responsibility, the Subcommittee will hold a hearing on May 2, 2007, on the availability and accessibility of needed dental services to low-income children eligible for Medicaid.

In connection with this hearing, I request that you provide the following information and documents no later than 5:00 p.m. on Friday, April 27, 2007:

1. The risk contract(s) between the Department of Health and Mental Hygiene ("the Department") and United HealthCare of the Mid-Atlantic, Inc. ("UnitedHealth") that were in effect during the period of enrollment by the late Deamonte Driver of Prince George's County, Maryland.

2. The amount paid on a monthly basis by the Department to UnitedHealth on behalf of Deamonte during the period of his enrollment in UnitedHealth.

3. The number of children under age 21 enrolled in UnitedHealth under the Maryland Medicaid Program and the Maryland Children's Health Program during calendar year 2006.

4. The total amount paid by the Department to UnitedHealth on behalf of all Medicaid enrollees and all Maryland Children's Health Program enrollees for the 12 months of calendar year 2006.

5. UnitedHealth's revenues (e.g., premiums, services, investment and other income), costs (medical costs, operating costs, depreciation and amortization), and earnings from operations under the risk contract with DHMH during calendar year 2006.

6. The dental services covered for children under the Maryland Medicaid Program and the Maryland Children's Health Program, by code, and the fee schedule used by each program during 2006 to reimburse dentists for such services, by code.

Memorandum April 27, 2007

TO: House Committee on Oversight and Government Reform
Subcommittee on Domestic Policy
Attention: Noura Erakat

FROM: Elicia Herz and Rich Rimkunas
Specialists in Social Legislation
Domestic Social Policy Division

SUBJECT: Analysis of Dental Participation Rates for EPSDT Eligibles Under Medicaid

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To assist you in preparation for your subcommittee hearing on May 2, 2007, at your request, we have analyzed selected data from the CMS-416 form which documents receipt of dental services among Medicaid children eligible to receive early and periodic screening, diagnosis and treatment (EPSDT) services. First, we provide a brief description of the EPSDT requirements and the contents of CMS-416 form. Then we provide data tables and a description of what these data show with respect to receipt of dental care among EPSDT participants.

Requirements of EPSDT under Medicaid

Most Medicaid children under age 21 are entitled to EPSDT services.[1] The Medicaid statute (Section 1905(r)) defines required EPSDT screening services to include:

- the basic screen (well-child visit) which, at a minimum, includes a comprehensive health and development history, a comprehensive unclothed physical exam, age-appropriate immunizations, laboratory tests (including lead blood level assessments appropriate for age and risk factors), and health education including anticipatory guidance,

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[1] Children classified as "medically needy" (in most states, a small subset of all Medicaid children), may be provided EPSDT at state option. Although an official count is not available, we believe that all states currently provide EPSDT to this group. In addition, as an alternative to traditional Medicaid benefits, the Deficit Reduction Act (DRA) of 2005 allows states to offer benchmark plans similar to coverage in the employer-based insurance market to many groups of Medicaid beneficiaries. This DRA option provides access to EPSDT as a "wrap-around" to these benchmark plans for Medicaid beneficiaries under age 19, not under age 21, as in traditional Medicaid.

- vision services which, at a minimum, include diagnosis and treatment for defects in vision, including eyeglasses,
- dental services which, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health, and
- hearing services which, at a minimum, include diagnosis and treatment for defects in hearing, including hearing aids.

In addition, medical care that is necessary to correct or ameliorate identified defects, physical and mental illness, and other conditions must be provided, including optional services that states do not otherwise cover in their Medicaid programs.

The Medicaid statute also requires the Secretary of HHS to develop and set annual EPSDT participation goals. In 1990, a participation goal of 80% was established for the basic screening service (i.e., well-child visits) for all states, to be achieved by 1995.[2] This goal has remained unchanged since that time. No goal has been set that is specific to receipt of dental services.

The CMS-416 Form

The Medicaid statute (Section 1902(a)(43)) also includes requirements for states to inform and arrange for the delivery of EPSDT services to eligible children, and also includes annual reporting requirements for states. The statute includes very explicit language regarding the minimum content for this state reporting form, and requires information on (1) the number of children provided child health screening services (i.e., well-child visits), (2) the number of children referred for corrective treatment, (3) the number of children receiving dental services, and (4) each state's results in attaining the participation goals set by the Secretary.

FY1990 was the first year for which state EPSDT experiences were required to be reported as the per Medicaid statute. States are required to submit these annual reports for each fiscal year by April 1st of the following fiscal year. For example, the FY2007 reports will be due on April 1, 2008, six months after the close of FY2007.

The tool used by the Centers for Medicare and Medicaid Services (CMS) – the federal executive branch agency responsible for implementation and oversight of the Medicaid program – to capture these required EPSDT data is called the CMS-416 form. As required by the Medicaid statute, this form captures data by age group and basis of Medicaid eligibility. Data are collected for a number of measures, some of which were added by CMS, and go beyond the minimum requirements laid out in the Medicaid statute. For example, the original HCFA-416 form captured only one measure of dental care – the unduplicated number of children receiving dental assessments. The revised CMS-416 form (effective as of FY1999) replaced this single dental measure with three separate measures that capture the unduplicated count of EPSDT eligibles receiving (1) any dental services, (2) preventive dental services, and (3) dental treatment services. Classification into one of these measures is based on specific dental procedure codes recorded on provider claims.

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[2] See Section 5360 of the CMS State Medicaid Manual.

You asked for information about the status of state submissions of CMS-416 data for recent years. **Table 1** below shows how many and which states submitted these forms to CMS for the FY2003 - FY2005 period, as of early April, 2007.

Table 1. Submission of CMS-416 Forms for FY2003 through FY2005, as of early April, 2007

States	FY2003	FY2004	FY2005
Alabama	✓	✓	✓
Alaska	✓	✓	✓
Arizona	✓	✓	✓
Arkansas	✓	✓	✓
California	✓	✓	✓
Colorado	✓	✓	✓
Connecticut	✓	✓	✓
Delaware	✓	✓	✓
District of Col.	✓	✓	✓
Florida	✓	✓	✓
Georgia	✓	✓	
Hawaii	✓	✓	✓
Idaho	✓		✓
Illinois	✓		
Indiana	✓	✓	
Iowa	✓	✓	✓
Kansas	✓	✓	
Kentucky	✓	✓	✓
Louisiana	✓	✓	✓
Maine			
Maryland	✓	✓	✓
Massachusetts	✓	✓	✓
Michigan	✓	✓	✓
Minnesota	✓	✓	✓
Mississippi	✓	✓	
Missouri	✓	✓	✓

States	FY2003	FY2004	FY2005
Montana	✓	✓	✓
Nebraska	✓	✓	✓
Nevada	✓	✓	
New Hampshire			
New Jersey	✓	✓	✓
New Mexico	✓	✓	
New York	✓	✓	
North Carolina	✓	✓	✓
North Dakota	✓	✓	✓
Ohio	✓	✓	✓
Oklahoma	✓	✓	✓
Oregon	✓	✓	✓
Pennsylvania	✓		✓
Rhode Island	✓	✓	✓
South Carolina	✓	✓	✓
South Dakota	✓	✓	✓
Tennessee	✓	✓	✓
Texas	✓	✓	✓
Utah	✓	✓	✓
Vermont	✓	✓	✓
Virginia	✓	✓	✓
Washington	✓	✓	✓
West Virginia	✓		
Wisconsin	✓	✓	✓
Wyoming	✓	✓	✓
Total	49	45	40

Source: Based on information received by the Congressional Research Service (CRS) from the Centers for Medicare and Medicaid Services (CMS). Includes CMS Form-416 submissions received by CRS as of April 4, 2007. Additional forms may have been submitted by states to CMS after this date, and are not reflected in this table.

About 75% of the states (38 of 51) had submitted the full set of FY2003 - FY2005 data to CMS by early April, 2007. Among the remaining 13 states, nine had submitted two of the three years of data. Seven of these nine states were missing the FY2005 data and two were missing the FY2004 data. Two states had submitted only one year of data (FY2003).

Finally, the remaining two states had submitted no data for these three fiscal years by early April, 2007.

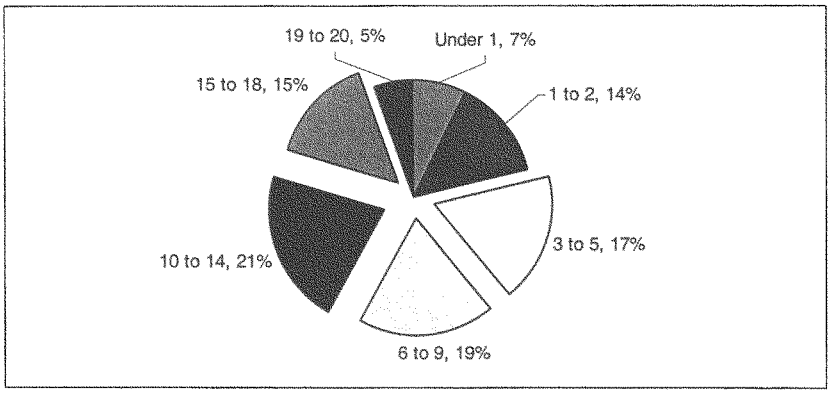
We also asked CMS for CMS-416 data for FY2006. These reports were recently due to CMS on April 1, 2007. As of April 20, 2007, CMS had received FY2006 CMS-416 reports from about 25 states. The agency is currently in the process of reviewing submitted data for FY2006 and following up with selected states with data questions as needed. Both staff from the CMS central office in Baltimore, and the CMS regional offices around the country review submitted 416 data.

In general, for a given fiscal year, CMS initially posts CMS-416 data to its website after review of individual state submissions, and when complete and approved forms are available for at least half of the states. Submitted data from additional states are added over time as they are reviewed and approved by CMS and a "critical mass" is available for subsequent posting. If states miss the deadline for submitting the 416 form for a given fiscal year, CMS regional office staff contact them to remind them of this reporting requirement. States can resubmit data for a given fiscal year at any time (e.g, if they discover an error in previously submitted data).

Distribution of the EPSDT Population by Age

Figure 1 shows the distribution of EPSDT eligibles by age group for FY2005, among all reporting states for that year (n = 40), as classified on the CMS-416 form. In total, there were 24.4 million EPSDT eligibles among reporting states in that year. The two smallest groups, at opposite ends of the age range, were infants (under age 1 at 7%) and young adults (ages 19 - 20 at 5%). Among the remaining children, the proportion of eligibles increased across the age range from 14% for those ages 1-2 years to 21% for young adolescents ages 10 to 14 years. Older adolescents (ages 15 to 18) comprised 15% of EPSDT eligibles across reporting states. (For background information, **Table A1** at the end of this memorandum provides detailed counts by state of individuals eligible for EPSDT and total eligibles receiving preventive dental services.)

Figure 1. FY 2005 EPSDT Eligibles for Reporting States, by Age Group



Note: Sum does not add to 100 percent because of rounding.
Source: Based on information received by the Congressional Research Service (CRS) from the Centers for Medicare and Medicaid Services (CMS). Includes CMS Form-416 submissions received by CRS as of April 4, 2007.

Dental Participation Rates

With respect to the first dental visit, the American Academy of Pediatric Dentistry (AAPD) recommends that every child be seen by a dentist following the eruption of the first tooth, but not later than 12 months of age. All other children should have additional periodic dental exams every 6 months (i.e., twice a year). Under Medicaid, states must adopt a dental periodicity schedule which can be state-specific based on consultation with dental groups, or may be based on nationally recognized dental periodicity schedules, such as the AAPD's guidelines.[3]

We do not have the state-specific periodicity schedules for dental care under Medicaid, and thus, we do not know which states follow national guidelines (like that recommended by the AAPD), or follow a different schedule. For the purpose of our analyses, we have assumed that all Medicaid children, regardless of age, should be seen by a dentist at least once a year.[4]

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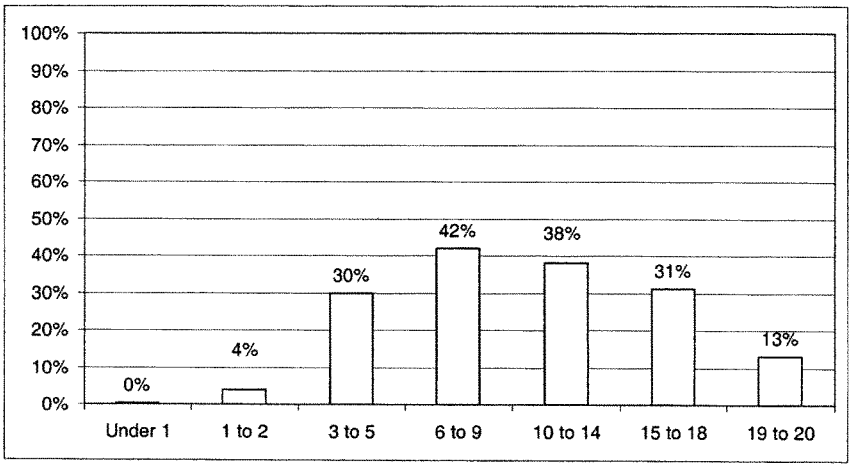
[3] See Centers for Medicare and Medicaid Services (CMS), *Guide to Children's Dental Care in Medicaid*, October 2004, and the American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment of Children*, last revised in 2003.

[4] We recognize that having a first dental visit before the age of one year may not be a common practice. Thus, we also analyzed preventive dental participation results excluding the under one age group (data not shown). On average, removing the under 1 age group generally increases the

(continued...)

Our analysis focuses on one of the measures of dental care available on the CMS-416 form – the receipt of preventive dental services. **Figure 2** shows FY2005 participation rates by age for all reporting states. Participation rates represent the proportion of all eligibles who received at least one dental preventive service during the fiscal year.[5] As these data show, school-age children between the ages of 6 to 9 had the highest receipt of preventive dental services at 42%, followed closely by children ages 10 to 14 with a participation rate of 38%. Young children ages 3 to 5 and older adolescents ages 15 to 18 had rates of about 30%. Other EPSDT eligibles at opposite ends of the age range had the lowest rates of preventive dental services (negligible for infants under age 1, 4% for children ages 1-2 years, and 13% for young adults ages 19-20 years.)

Figure 2. FY 2005 Preventive Dental Services Participation Rates for Reporting States, by Age



Source: Based on information received by the Congressional Research Service (CRS) from the Centers for Medicare and Medicaid Services (CMS). Includes CMS Form-416 submissions received by CRS as of April 4, 2007.

Table 2 provides information on preventive dental participation rates among reporting states for FY2003 through FY2005. With respect to state-by-state results, among those with at least two years of data, most showed modest increases of 1 - 6 percentage points in

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[4] (...continued)
calculated participation rate for each state by roughly 2 percentage points.

[5] The data shown in the accompanying figures and tables are unadjusted. We also did parallel analyses adjusting for the average period of enrollment to account for the fact that many Medicaid children are enrolled in the program for only part of a fiscal year. The effect of such an adjustment is to increase the reported participation rates. With some state-specific exceptions, the overall pattern of findings using unadjusted and adjusted data did not dramatically differ. For simplicity, we included only the results using the unadjusted data in this memorandum.

preventive dental rates. A few states showed modest declines of similar magnitude. For each fiscal year, the highest preventive dental participation rate ranged from 42 - 44% for Vermont. The lowest rate for both FY2003 and FY2004 was 1% for Hawaii, and 8% for Kentucky in FY2005.

Among reporting states combined, about 25% of EPSDT eligibles received at least one preventive dental service in FY2003, falling to 22% in FY2004 and rising again to 27% in FY2005. The dip in this "all states" trend is likely due at least in part to the large drop in the FY2004 participation rate for California, given the population size of this state relative to other reporting states. The dramatic change in the figures for California across years may be due to a data anomaly that we cannot identify nor make adjustments for. Other states also had seemingly anomalous patterns of preventive dental participation rates. For example, Hawaii's participation rates for FY2003 and FY2004 were 1%, climbing to 38% in FY2005.

Table 2. FY 2003 to FY 2005 Preventive Dental Service Rates, by State – Reporting States

State	FY 2003	FY 2004	FY 2005
Alabama	27%	31%	32%
Alaska	30%	31%	31%
Arizona	23%	23%	23%
Arkansas	20%	23%	23%
California	26%	4%	25%
Colorado	28%	28%	22%
Connecticut	26%	27%	25%
District of Columbia	18%	24%	25%
Delaware	21%	23%	24%
Florida	17%	17%	13%
Georgia	29%	31%	NR
Hawaii	1%	1%	38%
Idaho	26%	NR	32%
Illinois	20%	NR	NR
Indiana	33%	33%	NR
Iowa	34%	36%	36%
Kansas	23%	28%	31%
Kentucky	17%	13%	8%
Louisiana	24%	26%	26%
Maine	NR	NR	NR
Maryland	22%	23%	25%
Massachusetts	30%	31%	32%
Michigan	26%	29%	29%
Minnesota	28%	28%	30%
Mississippi	22%	32%	NR
Missouri	18%	18%	19%
Montana	19%	19%	20%
Nebraska	34%	38%	39%
Nevada	11%	10%	NR
New Hampshire	NR	NR	NR
New Jersey	23%	15%	17%
New Mexico	34%	36%	NR
New York	15%	16%	NR
North Carolina	28%	31%	33%
North Dakota	24%	21%	21%
Ohio	26%	28%	29%
Oklahoma	15%	24%	31%

State	FY 2003	FY 2004	FY 2005
Oregon	21%	21%	23%
Pennsylvania	23%	NR	23%
Rhode Island	28%	28%	30%
South Carolina	37%	39%	43%
South Dakota	26%	26%	32%
Tennessee	27%	31%	32%
Texas	36%	37%	37%
Utah	7%	6%	30%
Vermont	42%	42%	44%
Virginia	18%	20%	21%
Washington	35%	36%	38%
West Virginia	29%	NR	NR
Wisconsin	18%	18%	17%
Wyoming	24%	25%	27%
All Reporting States	25%	22%	27%

Note: NR – No state report information available.

Source: Based on information received by the Congressional Research Service (CRS) from the Centers for Medicare and Medicaid Services (CMS). Includes CMS Form-416 submissions received by CRS as of April 4, 2007.

Conclusions

In general, preventive dental participation rates among Medicaid children are low, both at the state-specific level and on average across reporting states. There are many potential reasons for these low rates including lack of participation in Medicaid among dentists, lack of awareness among beneficiaries about the importance of dental care to overall health and well-being, and data reporting problems, to name a few.

The accuracy of the data reported on the CMS-416 form is largely unknown, although this data analysis has pointed to a few potential problems for selected states. Reporting accuracy is particularly unclear with respect to Medicaid managed care. Across states, many Medicaid children are enrolled in managed care plans. In FY2003, based on expenditure patterns, nearly 80% of Medicaid children had some managed care experience, most with health maintenance organizations alone (31%) or in combination with specialty care plans (22%).[6] Historically, states have experienced problems obtaining detailed service delivery information from managed care plans. These problems would likely affect reporting of EPSDT well-child visits, since managed care plans often have responsibility for delivering these services to Medicaid children. However, with the exception of a few states, such managed care reporting problems may not be as prevalent for dental services since most dental care under Medicaid is probably not delivered through managed care systems. Hopefully, the testimony planned for your hearing on May 2nd will shed more light on this issue.

If you have questions about the data or analysis in this memorandum, please contact either Elicia Herz at 7-1377 or Rich Rimkunas at 7-7334.

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[6] See CRS report RL33711, *Medicaid Managed Care: An Overview and Key Issues for the 109th Congress*, by E. Herz.

Table A1. Individual Eligibles for EPSDT and Receiving Dental Preventive Services, FY 2003 to FY 2005. (Numbers in Thousands)

	Fiscal Year 2003		Fiscal Year 2004		Fiscal Year 2005	
State	Total Individuals Eligible for EPSDT	Total Eligibles Receiving Preventive Dental Services	Total Individuals Eligible for EPSDT	Total Eligibles Receiving Preventive Dental Services	Total Individuals Eligible for EPSDT	Total Eligibles Receiving Preventive Dental Services
Alabama	482	132	492	150	502	161
Alaska	87	26	88	27	89	28
Arizona	580	131	671	154	628	142
Arkansas	347	69	379	88	394	90
California	3,558	932	6,071	237	4,231	1,067
Colorado	262	74	303	86	390	87
Connecticut	269	69	275	74	286	70
D.C.	90	16	91	22	92	23
Delaware	76	16	79	18	83	20
Florida	1,571	272	1,627	270	1,680	224
Georgia	1,023	292	1,109	343	NR	NR
Hawaii	117	1	121	1	126	48
Idaho	145	38	NR	NR	156	50
Illinois	1,147	229	NR	NR	NR	NR
Indiana	573	186	593	196	NR	NR
Iowa	215	73	229	82	239	85
Kansas	203	47	212	59	220	67
Kentucky	340	58	318	42	320	26
Louisiana	694	167	733	188	763	195
Maine	NR	NR	NR	NR	NR	NR
Maryland	482	108	493	115	502	127
Mass.	496	147	480	150	493	158
Michigan	958	253	1,006	289	1,055	307
Minnesota	391	108	401	113	407	121
Mississippi	453	102	460	146	NR	NR
Missouri	655	120	685	126	685	128
Montana	63	12	65	12	66	13
Nebraska	167	57	157	59	159	62
Nevada	146	16	151	14	NR	NR
New Hampshire	NR	NR	NR	NR	NR	NR
New Jersey	500	113	535	81	554	96
New Mexico	319	108	329	118	NR	NR
New York	2,016	307	2,113	339	NR	NR
North Carolina	819	233	859	262	891	293
North Dakota	38	9	44	9	44	9
Ohio	1,104	288	1,154	321	1,189	348
Oklahoma	446	67	462	109	478	146
Oregon	272	57	274	59	279	63
Pennsylvania	942	217	NR	NR	1,070	241
Rhode Island	110	31	113	32	114	34
South Carolina	642	238	641	252	537	229
South Dakota	80	21	83	22	86	27
Tennessee	782	214	775	242	786	255
Texas	2,446	870	2,713	999	2,802	1,049
Utah	163	11	172	11	180	55
Vermont	72	30	73	31	74	33
Virginia	467	84	494	97	527	109
Washington	660	234	661	238	635	243

	Fiscal Year 2003		Fiscal Year 2004		Fiscal Year 2005	
State	Total Individuals Eligible for EPSDT	Total Eligibles Receiving Preventive Dental Services	Total Individuals Eligible for EPSDT	Total Eligibles Receiving Preventive Dental Services	Total Individuals Eligible for EPSDT	Total Eligibles Receiving Preventive Dental Services
West Virginia	217	63	NR	NR	NR	NR
Wisconsin	437	78	468	86	488	83
Wyoming	51	12	53	13	54	15
Reporting State Totals	28,174	7,037	29,306	6,382	24,354	6,627
Number of States Reporting		49		45		40

Note: NR – No state report information available.

Source: Based on information received by the Congressional Research Service (CRS) from the Centers for Medicare and Medicaid Services (CMS). Includes CMS Form-416 submissions received by CRS as of April 4, 200

STATEMENT FOR THE RECORD

AMERICAN DENTAL ASSOCIATION
TO THE
SUBCOMMITTEE ON DOMESTIC POLICY
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

ON

EVALUATING CHILDREN'S DENTISTRY UNDER MEDICAID

MAY 2, 2007

Chairman Kucinich and members of the subcommittee, the American Dental Association (ADA), which represents over 72 percent of the dental profession, thanks you for holding this hearing and calling attention to the need for improving access to oral health care for America's children. As you are well aware, the nation was shocked by the recent death of 12 year old Deamonte Driver—who lived only a short drive from here—from a brain infection apparently related to untreated dental disease. The American Dental Association extends our heartfelt condolences to the family of Deamonte. Clearly, the oral health care system failed this young

man. All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us.

The impact of poor oral health can, as this tragic case shows, go far beyond the mouth. It is well documented that poor oral health can lead to oral infections that can affect systemic health, and new evidence is emerging all the time. Oral bacteria have also been associated with bacterial pneumonia in bed or chair-bound patients, and might also be passed from mother to child resulting in a higher prevalence of caries in these children. Although it's not clear if treating an oral disease will improve specific health problems, we do know that oral health is important for overall health and vice versa.

Deamonte Driver's inability to obtain timely oral health care treatment underscores the significant chronic deficiencies in our country's dental Medicaid program. Fundamental changes to that program are long overdue, not simply to minimize the possibility of future tragedies, but to ensure that all low-income children have the same access to oral health care services enjoyed by the majority of Americans.

Disparities in Access to Oral Health Services

As U.S. Surgeon General David Satcher noted in his 2000 landmark report *Oral Health in America*, [1]dental caries (tooth decay) is the most common chronic disease of childhood – five times as common as asthma, and low-income children suffer twice as much from dental caries as children who are more affluent. According to the report, about 80 percent of the tooth decay

[1] Department of Health and Human Services (US). Surgeon General's report on oral health, 2000. Available from: URL: http://www.surgeongeneral.gov/library/oralhealth/

occurs in only about 25 percent of the children – children who are overrepresented in the lower socioeconomic strata. According to the Centers for Disease Control and Prevention (CDC), [2]our society as a whole has made real progress toward reducing the morbidity of oral disease; however, existing disparities among specific populations persist. For example, children from non-Hispanic black and Mexican-American populations and families below 200 percent of poverty have a greater amount of tooth decay that non-Hispanic whites and families above the 200 percent of poverty level.

Barriers to Accessing Oral Health Care Services

There are many barriers to providing every child from a low-income family in America with good oral health care services. Some of the barriers make it difficult to supply care (such as the geographic distribution of providers), some affect the demand for services (such as a caregiver's lack of appreciation of the importance of oral health), but all of them impact the ability of the underserved children to access dental services.

Supply Side Activities

On the supply side, the ADA promotes oral health through community-based initiatives, including water fluoridation, sealants and use of topical fluoride in public health programs and dental offices.

We also recognize adjustments in the dental workforce are necessary to address the special needs of underserved communities more effectively, especially those of children, and have endorsed

[2] Beltran-Aguilar ED, Barker ZK, Canto MT, et al. Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis: United States, 1988-1994 and 1999-2002. MMWR Surveill Summ 2005;54(3):1-44.

the development of a new member of the dental team – the Community Dental Health Coordinator (CDHC) – to do so. The CDHC will be a new mid-level allied dental provider who will enable the existing dental workforce to expand its reach deep into underserved communities and can be employed by Health Centers, the Indian Health Service, public health clinics, or private practices.

Congress must continue to fund crucial federal oral health care access programs. For many years, the ADA and the larger dental community have worked to ensure adequate funding for key oral health access programs within the Department of Health and Human Services (HHS) that provide dental research and education, as well as oral health prevention and community-based access programs. Each of these programs is important as a means of helping to ensure access to oral health care, especially for the disadvantaged children in our society.

Each year, the ADA and other national dental organizations work to ensure adequate support for the Health Resources and Services Administration's Health Professions Education and Training Programs[3]; HRSA's Maternal and Child Health Bureau (MCHB)[4]; the Centers for Disease Control and Prevention's Division of Oral Health[5]; the National Institute of Dental and

[3] Health professions education and training programs have a critical role in the recruitment and retention of minority and disadvantaged students and faculty. These programs are crucial if we are to address concerns with health disparities.

[4] Specifically, oral health projects in the Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), Title V, Special Projects of Regional and National Significance (SPRANS) account.

[5] The Centers for Disease Control and Prevention's Division of Oral Health (DOH) supports state- and community-based programs to prevent oral disease, promote oral health nationwide and foster applied research to enhance oral disease prevention in community settings. The CDC works with states to establish public health research that provides valuable health information to assess the effectiveness of programs and target populations at greatest risk. In addition, through the DOH, states can receive funds to support prevention programs that aim to prevent tooth decay in high-risk groups, particularly poor children, and reduce oral health disparities.

Craniofacial Research (NIDCR)[6]; the Ryan White HIV/AIDS Dental Reimbursement Program (Part F, Ryan White CARE Act) [7] ; and most significantly, the Title VII general, pediatric and public health dentistry residency programs within HRSA.[8] We call upon Congress to support these vital programs properly as part of our collective effort to fix the access problems for children from low-income families and other underserved.

The ADA is also very pleased to support H.R. 1781, the "Children's Dental Health Improvement Act of 2007," cosponsored by Representatives Dingell and Simpson. This legislation will do a great deal to improve delivery of dental care in Medicaid and SCHIP and ensure a chief dental officer presence in key federal agencies, among many other initiatives.

The ADA has long supported incentives at the federal level to encourage private sector dentists to establish practices in underserved areas, such as a tax credit to establish an office in an underserved area. We also work with and support our colleagues who practice in Health Centers, which are provided section 330 funding in exchange for providing care to all, regardless of ability to pay. We have an excellent working relationship with the National Association of Community Health Centers (NACHC) and encourage our private sector members to work cooperatively with the centers in their communities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers, thereby providing the

[6] NIDCR is the only Institute within the NIH that is committed to oral health research and training. Institute-sponsored research continues to link oral infection to such systemic diseases as diabetes, cardiovascular disease (heart attack and stroke) and adverse pregnancy outcomes (preterm birth and low birth weight). The Institute remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research.
[7] The Ryan White HIV/AIDS Dental Reimbursement Program increases access to oral health services for people living with HIV/AIDS; ensures that dental and dental hygiene students and dental residents receive the most current training; and assist in defraying the rising non-reimbursed costs associated with providing such care by dental education institutions.
[8] Title VII dental residency programs are instrumental in training dentists who work in underserved communities and treat Medicaid, SCHIP or other underserved populations, particularly those with special needs.

centers with another option to provide dental services efficiently to Health Center patients when and where those services are needed. In addition, the ADA was the founding member of the Friends of the Indian Health Service and for many years has actively lobbied to increase funding for the IHS's dental program, including full-funding for IHS loan repayments.

And dentists understand their ethical and professional responsibilities, too. In the absence of effective public health financing programs, many state dental societies joined with other community partners to sponsor voluntary programs to deliver free or discounted oral health care to underserved children. According to the *ADA's 2000 Survey of Current Issues in Dentistry*, 74.3 percent of private practice dentists provided services free-of-charge or at a reduced rate to one or more groups (e.g., homebound, handicapped, low income). A total national estimate of the value of this care was $1.25 billion, or $8,234 per dentist. In 2003, the ADA launched an annual, national program called "Give Kids A Smile" (GKAS). The program reaches out to underserved communities, providing a day of free oral health care services. GKAS helps educate the public and state and local policymakers about the importance of oral health care while providing needed and overdue care to large numbers of underserved children. The ADA's fifth annual Give Kids A Smile event on Feb. 2, 2007, was again highly successful. More than 53,900 dental team members registered to participate on ADA.org, including 14,220 dentists. Nationwide, 2,234 programs were held. Registered participants treated some 755,600 children, and valued the care at $72,276,000 ($95 on average per child). Of course, poor children shouldn't have to depend on charity for basic dental care. These efforts are important but are no substitute for fixing the Medicaid program.

Demand Side Activities

University researchers seeking to identify the barriers to oral health care faced by low-income caregivers concluded that efforts need to be made to educate caregivers about the importance of oral health for overall health. [9] The ADA and other professional dental organizations agree that early intervention is very important in assuring that a child has good oral health. Accordingly, the ADA recommends that children see a dentist for the first time within 6 months of the appearance of the first tooth and no later than the child's first birthday.[10] The American Academy of Pediatric Dentistry also recommends that all children visit a dentist in their first year of life and every 6 months thereafter, or as indicated by the individual child's risk status or susceptibility to disease.[11] The ADA is also undertaking a number of initiatives to address oral health literacy issues. They include: implementing an advocacy strategy to increase the number of school districts requiring oral health education for K-12 students; encouraging the development of oral health literacy continuing education programs to train dentists and allied dental team members to communicate effectively with patients with limited literacy skills; and developing guidelines for the creation of educational products to meet the needs of patients with limited literacy skills, including the involvement of targeted audiences in materials development.

Challenges Associated with the Medicaid Program

To address fully the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid. Over 90 percent of all practicing

[9] S.E. Kelly; C.J. Binkley; W.P. Neace; B.S. Gale, "Barriers to Care-Seeking for Children's Oral Health Among Low-Income Caregivers," *American Journal of Public Health*, Aug 2005; 95, 8; Alumni – Research Library, pg. 1345.
[10] American Dental Association, ADA statement on early childhood caries, 2000. Available from: www.ada.org/prof/resources/positions/statements/caries.asp.
[11] American Academy of Pediatric Dentistry, Guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Available from: www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf.

dentists are in the private sector (totaling over 162,000). Safety net facilities that target underserved populations are, of course, very important but they employ relatively few dentists. Efforts to expand care only through safety net facilities will not fix the access problem. For example, in fiscal year 2005, Health Centers receiving section 330 funding employed about 1,738 (FTE) dentists.[12] Even after significant growth in Health Centers in the past several years, that is still less than one percent of the total of 177,686 active dentists in the United States in 2005.[13]

Seventy-five percent of Medicaid enrollees are children and their parents, and about half of the program's 60 million 2006 enrollees are poor children, making it the federal government's largest health care program in terms of enrollment. [14] At the same time, according to the Congressional Budget Office (CBO), many eligible people do not enroll in the program and there have been estimates that about 33 percent of the 10 million children identified as uninsured are eligible for Medicaid. [15] So, experts estimate that over 30 million American children meet Medicaid eligibility requirements.

There are a number of factors that work against bringing more private sector dentists into the Medicaid program – but they can be overcome if we all work together. As CBO points out, analyses of Medicaid's reimbursement rates have found them to be lower than Medicare or private insurance rates.[16] This was also discussed in a General Accounting Office study that also

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[12] DHHS, HRSA, BPHC, 2005 Uniform Data System.
[13] American Dental Association, Survey Center.
[14] Congressional Budget Office, Medicaid Spending Growth and Options for Controlling Costs, Statement before the Special Committee on Aging, July 13, 2006, pp. 1-3.
[15] T.M. Selden, J.L. Hudson, and J.S. Ban thin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, vol. 23, no. 5 (September-October 2004), pp. 39-50.
[16] CBO, Ibid. at p. 4.

recognized a number of administrative barriers. [17] In short, the vast majority of the dental Medicaid programs in the United States are woefully under-funded and the reimbursement rates simply cannot attract enough dentists. Where these programs have been enhanced, the evidence is clear that dentist participation increases. In addition, high student debt pressures young dentists to go into the private sector and makes it fiscally less feasible to take public health or clinic positions. Significantly, the American Dental Education Association reported that indebtedness for dental school graduates averaged $118,720 in 2003, with public school graduates averaging $105,350 and private/State-related school graduates averaging $152,525. This level of debt puts a great deal of pressure on young dentists to set up private practices in relatively affluent areas to the exclusion of underserved areas.

Potential Solutions

In 2001, the Urban Institute wrote an early assessment of the State Children's Health Insurance Program (SCHIP) [18]and concluded that "....different delivery systems supported by competitive payments appears to be contributing to improved provider participation and better access to dental care in some state SCHIP programs." [19] Most important, the study noted what it called a "spillover" effect on the Medicaid programs in two states – Alabama and Michigan. [20] The authors stated that the Alabama and Michigan officials reported that the early success of their dental SCHIP programs had expedited reform of their dental Medicaid programs and that data

[17] General Accounting Office, "Oral Health ... Factors Contributing to Low Use of Dental Services by Low-Income Populations," September 2000. p.4.
[18] The Urban Institute, "Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Inititiatives," July 2001.
[19] Ibid, p. ix.
[20] Ibid.

suggested that improvements in access may be occurring under Medicaid programs that are paying dentists at market rates. [21]

In October 2004, the ADA identified five state and community models for improving access to dental care of the underserved.[22] The Michigan and Alabama programs mentioned above are included among them, with Tennessee's TennCare program the other state level Medicaid model program cited. The report also identifies two community level initiatives that show great promise of enhancing access to Medicaid eligible children. The Association chose these five based on suggestions from state policymakers and other public and private sector stakeholders.

A very recent study of the first five years of Michigan's "Healthy Kids Dental" Medicaid program[23] concludes that an increasing proportion of children received dental care each year from local providers close to home; the number of dentists continues to increase; and many of the children in the program appear to have a dental home and are entering regular recall patterns. Meanwhile, the Michigan Department of Community Health expanded the program to 59 of Michigan's 83 counties, effective May 1, 2006.[24]

Concerning the TennCare dental program, between October 2002 and October 2006, the number of dentists participating statewide grew by 112 percent and in rural counties by 118 percent.[25] This growth occurred after the dental program was "carved out" of the Medicaid medical

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[21] Ibid.
[22] American Dental Association, "State and Community Models for Improving Access to Dental Care for the Underserved," Executive Summary, October 2004.
[23] S.A. Eklund, "Michigan's Medicaid "Healthy Kids Dental" Program: Assessment of the First Five Years," University of Michigan School of Public Health.
[24] Ibid.
[25] J. Gillcrist, "TennCare Dental Program: Before and After the Carve Out"

program in 2002, whereby the dental care was administered by its own benefits manager and had its own funding stream, comprising only 2 percent of the entire TennCare budget. The carve-out facilitated the development of a good working relationship with the Tennessee Dental Association and other stakeholders, resulting in a streamlined dental administrative process, among other improvements. Four other states use a similar dental carve-out system – California, Illinois, Massachusetts (in progress), and Virginia. Finally, the Alabama program (Smile Alabama!) has also significantly improved dentist participation. State officials note the increase in reimbursement rates and its outreach to dentists as significant contributing factors in growing that program. [26]

To be clear, the Association is not suggesting that the programs identified in ADA's state and community models document are the only ways to begin to address the oral health access problems facing low-income children – or even the best ways in all cases. We are simply suggesting that while the problems are considerable, they are not insurmountable if all parties work together. We believe there is a great deal that Congress can do to encourage other states to take similar measures to improve their dental Medicaid programs through grants and other means.

In fact, the ADA supports a proposal for federal legislation that would offer States an inducement (a Federal medical assistance percentage equal to 90 percent) to sit down with stakeholders and develop dental Medicaid and SCHIP plans that would assure the Secretary of the Department of Health and Human Services that:

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[26] Smile Alabama! "Alabama Medicaid's Dental Outreach Initiative."

- children enrolled in the State plans have access to oral health care services to the same extent as such services are available to the pediatric population of the State;
- payment for dental services for children in the State plans are made at levels consistent with the market-based rates;
- no fewer than 25 percent of the practicing dentists (including a reasonable mix of general dentists, pediatric dentists and oral and maxillofacial surgeons) in the State participate in the State plans;
- administrative barriers are addressed to facilitate provider participation, including improving eligibility verification, simplifying claim form processing, assigning a single plan administrator for the dental program, and employing case managers to reduce the number of missed appointments; and
- demand for services barriers are addressed, such as educating caregivers regarding the need to seek dental services and addressing oral health care literacy issues.

The legislative proposal also provides for federal grants to support volunteer dental programs, a tax credit for donated dental services up to a maximum of $5,000 annually, and the pilot-testing of a Community Dental Health Coordinator (CDHC) model developed as a new mid-level dental professional who will work in underserved communities where residents have no or limited access to oral health care. CDHCs will provide community-focused oral health promotion, prevention and coordination of culturally competent care. Their services will include counseling individuals and groups toward better oral health and prioritizing population/patient group needs to identify potential emergent dental care needs, as well as providing clinical services, such as individual preventive services (such as fluoride and sealant applications) and performing

temporization on dental cavities with materials designed to stop the cavity from getting larger until a dentist can see the patient.

Conclusion

All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us. Fundamental changes to the Medicaid program are long overdue to ensure that low-income children have the same access to oral health care services enjoyed by the majority of Americans. While we have made progress toward reducing the morbidity of oral disease, significant and persistent disparities continue to adversely affect underserved populations.

Dentists understand their ethical and professional responsibilities and have tried to address the access dilemma in a variety of ways. The ADA promotes oral health through community-based initiatives, such as water fluoridation, sealants and use of topical fluoride in public health programs and dental offices. We endorse adjustments in the dental workforce, including the development of Community Dental Health Coordinators, who could greatly enhance the productivity of our dental teams in the future and will bring the expertise needed to address the oral health care needs of many in underserved populations, especially children in low-income families. For many years, the Association has lobbied Congress to adequately fund oral health care access programs, such as the Health Resources and Services Administration's Health Professions Education and Training Programs, which is crucial in addressing concerns with health disparities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers and many state dental societies cosponsor voluntary programs to

deliver free or discounted oral health care to underserved children. Of course, all of the above efforts are no substitute for fixing the Medicaid program.

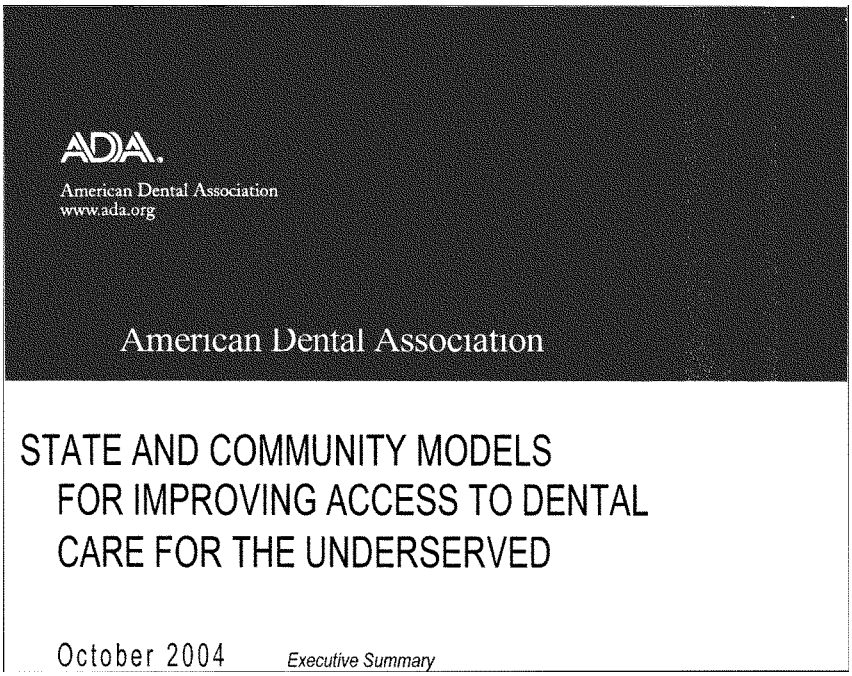
To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid. Over 90 percent of practitioners are in the private sector, and with over 30 million children estimated to be Medicaid-eligible, there is simply no other way to adequately serve such a large segment of our nation. We have cited examples of several states that have made great strides in fixing their Medicaid programs, such as the "Healthy Kids Dental" in Michigan, "TennCare" in Tennessee and "Smile Alabama!" in Alabama. There are certainly many more examples, especially at the community level, that have also been effective.

We believe there is a great deal that Congress can do to encourage other States to take similar measures to improve their dental plans. For example, the ADA supports a federal legislative proposal that provides the States an option to fundamentally change their Medicaid and SCHIP plans by bringing many more dentists into the programs, supporting volunteer programs that provide free care, offering a limited tax credit for donated dental services, and funding pilot testing of a new mid-level dental provider (Community Dental Health Coordinators) who will serve as the link between oral health professionals and the underserved communities – helping to greatly reduce the possibility of future tragedies.

The problems are numerous and complex, but they are not insurmountable if we have the will to take the necessary steps to fix this problem. For too long, dental disease has been the "silent

epidemic." The tragic fate of young Deamonte Driver—and the many others who have died from untreated dental disease—show the gravity of untreated dental disease.

Mr. Chairman, our nation's most vulnerable citizens deserve better care than we have provided. The ADA stands ready to do its part, and we call upon our many friends in Congress to work with us to ensure that every child can face his or her future with a smile.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STATE AND COMMUNITY MODELS
FOR IMPROVING ACCESS TO DENTAL
CARE FOR THE UNDERSERVED
October 2004
Executive Summary

American Dental Association *State and Community Models for Improving Access to Dental Care For the Underserved—A White Paper.* Chicago American Dental Association· October 2004

To obtain a complete copy of *State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper,* go to www.ada.org or e-mail access@ada org

VISION STATEMENT

With each passing year, science uncovers more evidence of the critical importance of oral health to overall health. Early diagnosis, preventive treatments and early intervention can prevent or halt the progress of most oral diseases-conditions that, when left untreated, can have painful, disfiguring and lasting negative health consequences. Yet millions of American children and adults lack regular access to routine dental care, and many of them suffer needlessly with disease that inevitably results. Oral health access problems cut across economic, geographic and ethnographic lines. Racial and ethnic minorities, people with disabilities, and those from low-income families are especially hard hit.

The nation's dentists have long sought to stem and turn the tide of untreated disease, as individuals, through their local, state and national dental societies, and through other community organizations. Dentists alone cannot bring about the profound change needed to correct the gross disparities in access to oral health care. But dentistry must provide the leadership that initiates change, or it will not occur.

Ultimately, education and prevention will be the linchpins in eliminating, or at least minimizing, untreated dental disease. The day that we as a nation decide to provide oral health education to families of newborns, public health measures such as community water fluoridation, and regular dental visits to every American will mark the birth of the first generation that could grow up essentially free of dental disease. Until that occurs, the nation will be challenged to meet the needs for preventive and restorative care among large numbers of Americans who do not have dental coverage, cannot afford care or face other challenges that prohibit them from seeking regular oral care and dental visits.

The American Dental Association and its members will continue working with policymakers to establish programs and services that improve access to oral health care. We urge the nation to join us in:

- Rejecting programs and policies that marginalize oral health, and instead supporting those that recognize that oral health is integral to overall health and can affect a person's self esteem, ability to learn and employability.
- Acknowledging that the degree of oral health disparities and the extent and severity of untreated dental disease-especially among underserved children-is unacceptable.
- Committing, through both advocacy and direct action, to identify and implement commonsense, market-based solutions that capitalize on the inherent strengths of the American dental care system and that make it possible for all Americans, regardless of their financial, geographic, physical or other special circumstances, to experience optimal oral health care.

EXECUTIVE SUMMARY

BACKGROUND: Oral health means much more than healthy teeth and gums. It is integral to overall health, self-esteem, ability to learn and employability. The 2004 white paper State and Community Models for Improving Access to Dental Care for the Underserved is the latest in a series of ADA publications, programs, symposia and other initiatives aimed at state and federal policymakers, the public health community, the media, other opinion leaders, the dental profession and the general public about the extent of unmet need for dental care among large groups of Americans. The poor—including low-income elderly—the disabled and residents of those rural and inner city areas where attracting a dentist is difficult, are particularly hard hit.

Dentists provide billions of dollars in charitable education, screening, preventive and restorative services, both as individuals and through their local, state and national professional societies. But charity care alone—even of this scope—is not a long-term solution to making oral health care accessible to the millions of Americans who do not get it.

BARRIERS TO CARE: Federal law requires states to cover dental benefits for Medicaid eligible children. All states except Texas and Delaware also provide dental services to children eligible for the State Children's Health Insurance Program. But with a few exceptions, these programs—typically underfunded and poorly administered—provide dental services to only a small percentage of those eligible. Access to dental care for low-income and disabled adults is exponentially worse, with few public assistance programs providing adequate coverage.

- Medicaid reimbursement rates are often so anemic, and administrative burdens so onerous, as to discourage provider participation. In many cases, reimbursement rates fail to cover even dentists' overhead costs in providing care.
- Even when care is available, programs often fail to provide the case management services needed to help people get to dental appointments and comply with post-treatment instructions and oral hygiene protocols.
- Low levels of oral health literacy lead to often-severe dental disease that could otherwise be prevented cheaply and easily.
- Economic conditions discourage dentists from practicing in some inner city and rural areas, creating location-specific dentist shortages.

MARKET-BASED SOLUTIONS: Working with other stakeholders, the ADA has researched extensively the problems plaguing dental public assistance programs and the innovations under way in some states and localities to address them. This paper examines five models, three at the state level and two at the community level, which other states and communities could adopt, modifying them as appropriate to meet the specific needs of their residents.

1) Michigan's Healthy Kids Dental Medicaid demonstration program is a partnership between a state Medicaid program and a commercial dental plan, with the plan managing the dental benefit according to the same standard procedures and payment mechanisms it uses in its private plans. The proportion of Medicaid eligible children who saw a dentist at least once increased from 32 percent to 44 percent in the pilot program's first year. This model demonstrates how contracting with a single commercial entity that 1) has a strong existing dental network, 2) offers competitive market- based reimbursement and 3) streamlines administration to mirror the private sector can substantially improve access to care for Medicaid beneficiaries.

2) Tennessee's TennCare program was the first attempt by a state to move its entire Medicaid population into a statewide managed-care system. The impact on dental services was disastrous. The number of participating providers dwindled from its 1984 level of more than 1,700 to 386 general and specialist dentists available to treat the more than 600,000 TennCare eligible children. In 2002, the legislature enacted a statutory carve-out of dental services, which mandated a contract arrangement between the state and a private dental carrier to administer benefits for children (under age 21). The state retained control of reimbursement rates and increased them to market-based levels.

EXECUTIVE SUMMARY CONTINUED ON BACK

The new rate structure, in combination with administrative reforms, patient case management strategies and a requirement that the carrier maintain an adequate provider network, has substantially improved TennCare's provision of dental services. In just two years, the utilization rate among eligible beneficiaries has increased from 24 percent to 47 percent (Private sector utilization ranges from 50 percent to 60 percent). As of June 2004, about 700 dentists were participating in the program, with 86 percent of participants accepting new patients.

3) Alabama reformed its state-administered dental Medicaid program in 2000 to reimburse dentists at rates equivalent to those paid by commercial insurers. (The program still reimburses dentists at year 2000 rates.) The changes included creation of the Smile Alabama! initiative, which encompassed administrative reforms, a case management program, and increased outreach to both patients and dentists. The number of participating dentists has increased 47 percent, from 441 in 1999 to 674 in June 2004. The increased workforce resulted in increased utilization—26 percent of eligible children saw a dentist in 1999; in 2003 39 percent of eligible children had at least one dental visit.

4) The Connecticut Health Foundation has been a leader in exploring contracting between federally qualified health centers (or similar public health clinics) and private practice dentists to provide care to underserved patients. Under these contracts, the health centers and dentists negotiate the types and amount of services to be provided. Dentists do not need to be Medicaid providers to treat Medicaid patients—the health centers are responsible for billing Medicaid for the services.

5) In Brattleboro, Vt., Head Start, the state health department, school officials and hospital administrators collaborated to establish a fee-for-service, for-profit dental center to address the needs of the underserved in a rural community. The practice serves both private paying and public assistance patients and pays a percentage of non-Medicaid revenues to the non-profit contracting entity (the community partners). In its first two years of operation, the clinic has cleared a huge backlog of children with acute and chronic dental needs and has begun to increase adult utilization as well.

The models in this white paper exemplify innovative ideas that could help other states and communities increase access to critically needed oral health services for their underserved populations. They were selected based on suggestions from state policymakers, public health representatives, state dental directors, the dental insurance industry and private-practice dentists. They reflect the consensus among these stakeholders that only through public-private collaborations will the nation make substantive progress in improving access to care for the underserved.

Ultimately, the success of these models will hinge on the quality of individual programs—financing, administrative processes and case management services, and their success in recruiting participating dentists. Their promise is that they are designed and implemented by the states or communities they will serve, allowing them to work toward meeting local needs according to local resources. Local and state dental societies stand ready to explore these collaborative models with community leaders for the improvement of the oral health of the American public.

Alabama Medicaid's Dental Outreach Initiative

Bringing healthy smiles to all of Alabama's children is the goal of
Alabama Medicaid Agency's dental initiative, "Smile Alabama!"

Dentists Signing on With Medicaid Program

Since Governor Don Siegelman announced Alabama Medicaid Agency's dental initiative "Smile Alabama!" in October 2000, the agency has added more than 300 new dentists to its roster of professionals who treat the state's Medicaid children.

A major goal of the "Smile Alabama!" initiative is to increase the number of Medicaid dental providers. The first step to fulfilling this goal came when Medicaid's reimbursement rates for dental care were increased up to the average rates of the state's largest insurer, Blue Cross/Blue Shield.

In its effort to recruit new providers and retain currently enrolled dentists, the agency conducts one-on-one visits with dentists to further identify any problems and provide assistance with provider issues. Regional meetings are conducted to provide additional information about "Smile Alabama!" and explain Medicaid's Dental Program. Matching funds from public and private sources support the initiative grant from the Robert Wood Johnson Foundation's 21st Century Challenge Fund. Initiative partners include Alabama Power Foundation, Inc., Alabama Department of Public Health, West Alabama Health Services, and the University of Alabama at Birmingham.

Other Aspects of the Program

There are four components of the Dental Outreach Initiative.

1. Dental Reimbursement
2. Claims Processing
3. Patient Outreach
4. Provider Outreach

The Objectives of the Dental Outreach Initiative

- Provide adequate provider training and support, face-to-face
- Provide patient education on importance of prevention
- Provide training on the use of Targeted Case Management to address the no-show problems with Medicaid recipients
- Conduct provider recruitment visits
- Provide provider assistance with regularly scheduled follow-up calls
- Provide recipient education resources to providers
- Provide continued patient education resources/tools
- Assessment of success/failure to achieve program goals.

Making it work

Funding will be necessary to ensure the success of the Smile Alabama! Initiative. The governor committed $2 million in new state dollars to the Alabama Medicaid Dental Program in 2000 for a total of $6.5 million for dental rate increases. Medicaid continues to pursue additional funding sources to support the outreach component of the initiative.

Claims Processing Changes

- Increase the consistency of the Medicaid claim submission format with that of other payors
- Provide adequate training and continued technical support for claims submission
- Maintain an effective and efficient claims processing system
- Provide timely responses to provider inquiries and claims resolution

Dental Reimbursement

- Increase rates to 100% of BCBS 2000 rates *(Implemented in October 2000)*
- Implement an annual rate review and necessary adjustments

Provider Outreach

- Encourage and support appropriate utilization of dental services
- Increase the number of patients accessing appropriate dental services
- Increase the number of providers who accept Medicaid patients
- Increase the number of providers who participate in early education of Medicaid-eligible dental patients

Recipient Outreach

- Increase the number of Medicaid recipients who make and keep appointments
- Increase the number of Medicaid recipients who know what to expect when visiting a dental office and what is expected of them (Rights & Duties)
- Increase the number of Medicaid recipients who are compliant with the usual policies and procedures followed in a dental office
- Increase the number of Medicaid recipients who practice basic preventive

at-home dental care, with emphasis on the very young child

Dentists with any questions about the Alabama Medicaid Dental Program should call 334-242-5997 for additional information. Dental providers experiencing problems in resolving claims issues or with policy questions should also call this number.

The State of Alabama is committed to making our vision, "To insure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well being of the child" a reality.

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