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INSURING BRIGHT FUTURES: IMPROVING ACCESS TO DENTAL CARE AND PROVIDING A HEALTHY START FOR CHILDREN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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INSURING BRIGHT FUTURES: IMPROVING ACCESS TO DENTAL CARE AND PROVIDING A HEALTHY START FOR CHILDREN

TUESDAY, MARCH 27, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:10 a.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Towns, Green, DeGette, Capps, Allen, Baldwin, Engel, Solis, Hooley, Matheson, Deal, Murphy, Burgess, Blackburn and Wilson.

Staff present: Elizabeth Ertel, Yvette Fontenot, Brin Frazier, Amy Hall, Christie Houlihan, Bridgett Taylor, Lauren Bloomberg, and Robert Clark.

OPENING STATEMENT OF HON. FRANK PALLONE JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I want to call the subcommittee to order.

Today we are having a hearing on "Insuring Bright Futures: Improving Access to Dental Care and Providing a Healthy Start for Children." I now would recognize myself for an opening statement.

I would like to thank our witnesses for appearing before the subcommittee today and I am certain that we will learn much from your expertise. Today's hearing was brought about after a 12-year-old Maryland boy lost his life because he was unable to access the dental care he needed to treat an abscessed tooth. What started out as a simple toothache quickly developed into a far worse problem that cut the boy's life far too short. When news of this tragedy spread throughout the country, many people were shocked. It was unimaginable to think that something as minor as a toothache could have such dire consequences.

Indeed, for most of us, we take for granted the convenience of going to see a dentist, but the truth of the matter is, for millions of Americans, proper dental care is often out of reach and sadly, most of those people are children. Indeed, the truly frightening thing about Diamonte Driver's death is the number of American children who are at risk of a similar fate. The problem of poor oral health is nationwide and impacts millions of children. There has al-

ready been another boy in Mississippi who died because of delayed dental care.

Now, the question is: just how big is this problem? Statistics show that chronic infectious disease that causes cavities remains second only to the common cold in terms of prevalence in children. Unlike a cold, however, tooth decay does not go away; it only gets worse. Pain from untreated dental disease can make it difficult for children to eat, sleep, pay attention in school, and it can affect their self-esteem. Poor children are more than twice as likely to have cavities than children who come from wealthier households. Medicaid is able to provide comprehensive dental care to many low-income children through its early periodic screening, diagnosis and treatment benefits. Similarly, many States provide dental benefits as part of their children's health insurance programs, and I have no doubt that if it were not for these two programs, the problems that our children face in securing primary dental care would be exponentially worse.

But clearly, we need to do more. There are many children who are eligible for Medicaid or SCHIP who are not enrolled. That means that there are millions of children who should be receiving dental care but are not, and we need to invest more funds to improve enrollment in these important programs and provide the financial resources to ensure that they can access the benefits once they are enrolled. But there are many children who are not eligible for public health insurance programs who are unable to also receive proper dental care.

When I am home in New Jersey and I am visiting a community health center or a hospital clinic, I see firsthand how difficult it is for low-income families to obtain primary dental care. The community health centers that I talk to describe the difficulty they have in securing dentists to provide care to their patients, and I look forward to hearing from our witnesses about their recommendations on how Congress might be able to encourage dentists to provide care in many of these underserved communities. But the problem of access to dental care goes even further. For millions of Americans who have health insurance, dental benefits are often not included. Indeed, millions of families who obtain their health insurance from their employers do not have policies that cover dental care, leaving them with few places to seek care.

I truly believe that we are seeing a crisis when it comes to dental care for kids but poor oral health is just the tip of the iceberg. It certainly is not the only health care problem affecting our Nation's children. Obesity, for example. Obesity rates among adolescents have doubled in the past two decades and now affects 16 percent of children ages 16 to 19. When compared with other developed countries, it is very clear that our fragmented health system is failing our children, and as a consequence, our children are suffering. The United States maintains higher rates of infant and child mortality, higher prevalence of asthma, and injuries and rapidly increasing rates of mental health problems with a limited ability to respond. Congress can and should do more to address these problems. Unfortunately, over the years, the interest of our children has often taken a back seat to more politically powerful interests. Unfortunately, I think that it has been too easy for previous Con-

gresses to overlook the needs of our children simply because they lack the political voice that other groups might have, and that clearly needs to change. Our Nation's children can no longer wait for Congress to act on this pressing health issue. The longer we wait, the more children we put at risk.

A Nobel laureate and poet, Gabrielle Mistral, said, and I quote, "Many things we need can wait. The child cannot. Now is the time. His bones are being formed, his blood is being made, his mind is being developed. To him, we cannot say tomorrow. His name is today." And I don't know if it is proper but I will say that because this is so important, I have my own wife and children here today listening to the hearing, at least in the beginning, and I mention that only because I can relate to the problems that these kids face and it is one of the reasons that I am particularly interested in it because I have children of my own.

So with that, I will yield back my time and recognize the ranking member, Mr. Deal, for an opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman, and welcome to our panelists and to our guests, and I am pleased to see Mr. Pallone's family here too and I see at least one set of braces over there so he is contributing to the industry, I might add.

I understand we have some special guests in our audience today, Mr. Chairman, some members of the American Dental Association. If it would be appropriate, I would like to see them if they would raise their hands, please. Don't be bashful. Oh, there they are. Oh, they are everywhere. I thought they were a bigger crowd than that. Well, let me thank you for being here. Certainly this is an important component of addressing the future needs of dental services in our country. My State, I am told, that we have about 240 dentists every year who are retiring and we are only graduating about 60, as I understand it, from our dental schools. So it is important for you to continue in your educational pursuits, and we thank you for coming today.

Our hearing today is an essential element of focusing on essential elements of children's care and that is their dental care, and I would thank our witnesses and I look forward to their testimony. Our witnesses, I am sure, today will tell us that there are a number of barriers to proper oral health care despite the fact that all States must provide dental services as a part of their Medicaid programs and every State with an SCHIP program includes dental benefits. It seems that the impediments to adequate coverage in the public programs exist not necessarily because the benefit does not exist. For instance, many dentists choose not to participate in the public programs. In 2000, only about a quarter, 26.3 percent, of dentists participated in the Medicaid program. Also in my conversations with dentists, many cite the overwhelming administrative burden of providing services through the public programs. I believe it is shortsighted to point only to reimbursement levels when dentists will choose to provide their services on a pro bono basis rather than participate in the public programs. Moreover, many people do not recognize the importance of oral health and simply

fail to take advantage of the benefits that are available to them. This is true for both individuals covered by private and public insurance. Dental services are certainly an important component of health care coverage but encouraging individuals to take advantage of provided benefits seems equally important. At some point, people must take responsibility for their oral health on a regular basis.

I am afraid that many in our committee have an interest in creating mandates with SCHIP like the dental benefit in Medicaid which would make it more difficult for States to provide health coverage appropriate to the needs and conditions of the individual States. The Governors' frequent frustration with the rigid structure of the Medicaid program helped inform the steps we took in the Deficit Reduction Act to provide benefit flexibility to the States in Medicaid. This flexibility allows Governors to design effective programs which meet the specific needs of their State. Dr. Scheppach will tell us how the flexibility of the SCHIP program contributes significantly to its success. I fear that if we remove the flexibility of SCHIP, we will seriously hamper the States' ability to design innovative health care reform proposals to cover their uninsured.

In these discussions about SCHIP and Medicaid, it is also too easy to lose sight of the role played by free clinics, health centers and collaborations like the Health Access Initiative in my hometown, and we will have a speaker on the next panel to talk about it. These organizations provide an effective way to bring health care to the uninsured. For instance, in the case of dental care, dentists who may want to avoid the administrative burden of the Federal programs but still want to help meet the needs of their local community could volunteer their time at a clinic. I hope the committee will spend time examining ways to make these initiatives and institutions more effective, perhaps through liability reform or even providing a tax deduction to physicians who provide their services for free in a clinic setting.

I look forward to the testimony of the witnesses today and to their insights into this very distinct and unique problem, and I am sure that we will be informed by your testimony. Thank you for being here.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Deal.

I now recognize our vice chair, Mr. Green from Texas.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding this hearing on access to dental care for our Nation's children.

I am glad that one of our early hearings on access issues will highlight dental care because it is such an important component of children's health care. Tooth decay remains the most prevalent chronic health care condition faced by our children today, which is why dental issues should be part of our discussion involving increased access to health care. A lack of access to dental care is no different from other health care since the effect of inaction is the same. Without preventive dental care, dental problems are often left untreated until they reach emergency proportions and the patient arrives in the hospital emergency room with a condition that

could have been treated earlier and at much lower cost. In fact, Medicaid statistics show that the cost of managed dental problems through preventive dental care is 10 times less costly than inpatient dental treatment in hospital ERs. Despite the obvious benefit of preventive dental care, we have serious uninsured problems with dental benefits that restrict access to care. In fact, for every child who goes without health insurance, there are three children who lack dental insurance. This discrepancy leaves children without insurance being five times as likely to have unmet dental needs than their classmates who have insurance.

Unfortunately, Congress contributed to this disparate treatment of dental and health insurance when it created the State Children's Health Insurance Program in 1997. While States that use SCHIP dollars to expand their Medicaid programs had to include the full range of dental benefits provided to the traditional Medicaid population, Congress made the dental benefit optional for States like Texas, who have separate SCHIP programs. The result, when funding got tight and State legislators got a little uncomfortable about balanced budgets, the SCHIP dental benefit found itself on the chopping block and I am sorry to say that is exactly what the Texas Legislature did in 2003 when it was the first State in the country to eliminate the SCHIP program's dental benefit. I understand the State of Georgia is considering a similar tactic and I assure my friends in Georgia that the elimination of this critical benefit is a misguided health policy. In fact, we may have an amendment we might call the Charlie Norwood amendment since Dr. Norwood served on our committee a very long time and passed away recently and was a dentist in Georgia.

In Texas, public outrage over SCHIP dental policy and other cuts led the State legislature to restore the benefit in 2005. Unfortunately, the Texas children got only half a loaf with the Texas SCHIP program imposing $175 annual cap on preventive and diagnostic services and a $400 cap per enrolled child on therapeutic services like tooth extractions and root canals. Despite being passed in 2005, the benefit only became available to Texas children in the beginning of April 2006, meaning that too many of the 300,0000 Texas children that remain on SCHIP rolls went far too long without dental checkups and preventive services.

The recent news of the 12-year-old child in Maryland who died tragically and needlessly from complications of untreated dental infection sheds an unmistakable light on our children's needs for increased access to dental care. Sadly, the problem is not limited to Maryland. In fact, 46 counties out of our 254 in my State of Texas do not have a practicing dentist. Without access to dental care, the children living in these counties and similar communities throughout the country have little more than hope to ensure that their dental health does not deteriorate into irreversible health problems.

I want to thank the chairman for drawing attention to this as we focus on improving access to health care and specifically the SCHIP reauthorization. I hope that we will take the opportunity to address the dental needs of our children and do everything possible to increase their access to critical dental care, and again, I thank our witnesses on our two panels today, and I yield back my time.

Mr. PALLONE. Thank you, Mr. Green.

I recognize the gentlewoman from Tennessee, Mrs. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. I thank the chairman for holding this hearing today and I want to extend my welcome to your family. Also, I appreciate the panel that is before us. I am delighted that we have a diverse panel of witnesses who have assembled for us today.

I think we all agree that lack of access and lack of knowledge of how to use that access when it comes to dental health services for children is a serious problem. It is also a frustrating problem and it is one that could be remedied and should be remedied with some commonsense, practical solutions. We all know the Centers for Disease Control numbers that nearly 25 percent of our children under age 5 are affected by dental decay and half of our children age 12 to 15 are affected. We know that low-income children are the hardest hit and that about half of those 6 to 19 have untreated decay, absolutely phenomenal numbers when you think about this being 2007. We also know that these untreated cavities can cause pain, dysfunction, absence from school, underweight, poor appearance, all items that greatly affect a child's ability to be successful in their current life and in their future life, and these facts are disturbing to all of us.

At a time when we are shifting from responsive medicine to preventative medicine, there is no excuse for allowing the problem to continue. We all had grandmothers who would quote to us, "an ounce of prevention is worth a pound of cure." We should apply this to the problem of children's dental health. Not only is proper oral care common sense, it is also extremely cost-effective and provides significant savings of health care dollars during an individual's entire lifetime.

I am looking forward to hearing the testimony today and working with all of you on how we can best address the situation, how we consider SCHIP, how we allow States flexibility, and how we continue and allow health care innovation. I am looking forward to a thoughtful consideration of the options before us.

I yield back.

Mr. PALLONE. Thank you.

I recognize the gentlewoman from Colorado, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, Mr. Chairman. I would ask unanimous consent to put my full statement in the record and simply point out that as we consider the need for dental coverage for children, we also need to think about the need for more dental providers to give those children care.

The title VII primary medicine and dentistry cluster plays a critical role in our Nation's health care safety net. Programs supported by title VII produce an essential pipeline for a number of essential medical providers, general and pediatric dentists who go on to work

in community health centers, rural health clinics, inner city urban clinics, hospitals and dental school clinics, exactly the providers that serve the populations we are talking about today. These are the places where the SCHIP kids are enrolled and other indigent kids who don't have any other recourse to dental care. Funding for all of title VII has been drastically cut in the last few years, which severely constricts our pipeline for dentists. I hope the witnesses today will talk with us about the challenges faced in States to meet the demand for dentists, because if we don't have dentists, it is going to be hard to see how we can give all of our kids dental care.

One other issue I want to mention, as we look at the reauthorization of SCHIP, we need to examine, as Mr. Pallone says, the holistic needs of the child, not just the dentistry, not just the medical needs, but we also need to look at mental health for the kids and I think that is widely underestimated. I also serve on the Oversight and Investigation Subcommittee which had a hearing last week about the medical infrastructure of New Orleans and trying to rebuild after Hurricane Katrina. Over and over again, we heard from providers in community health centers about the unbelievable need for mental health services. This is particularly true for children who have lost everything, who are depressed and who in many cases have suffered post-traumatic stress disorder yet while we know the need for mental health care services is severe in the hurricane-affected regions, the need is no less acute for other children around the country. Many face mental and behavioral health problems as well as developmental disabilities that require extensive care and that is care that they are currently unable to afford. I know the primary purpose of this hearing is dentistry but on the second panel we have witnesses who can help us talk about these other challenges for children and how we can use SCHIP more effectively to address their needs.

Mr. Chairman, reauthorization of SCHIP is of paramount importance both to myself and to this committee in the next few months. As we do so though, we need to make sure that we carefully consider all of the health needs of those children and how we can best meet them.

I yield back the balance of my time.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mr. Chairman, thank you for calling this hearing today. As we prepare to reauthorize the State Children's Health Insurance Program (SCHIP) it is critical that we ensure that the benefits provided through this program effectively meet the health care needs of the children enrolled.

As we have all heard, two young boys—one in Maryland, one in Mississippi—recently lost their lives when an infection from an abscess tooth spread into their blood. In both cases, each boy lacked health insurance with dental coverage. Instead of a minor procedure in a dentist's office, the boys were rushed to the emergency room, underwent extensive surgery, and eventually died. In the case of the boy in Maryland, $250,000 worth of care was spent to keep him alive. Covering this boy in SCHIP with proper dental coverage would have prevented this from occurring.

As we consider the need for dental coverage for children, I hope that we can also discuss the need for more dental providers to give care. The Title VII Primary Medicine and Dentistry cluster plays a critical role in our Nation's health care safety net. Programs supported by title VII produce an essential pipeline for a number of essential medical providers, general and pediatric dentists who go on to work in community health centers, rural health clinics, inner city urban clinics, hospitals and den-

tal school clinics. These are the very places that provide much of the dental care to those children enrolled in SCHIP. Funding for all of title VII has been drastically cut in recent years, severely constricting our pipeline for dentists. I hope that our witnesses will be able to share with us today the challenges faced in states to meet the demand for dentists.

Mr. Chairman, in addition to the Health Subcommittee, I also serve on the Oversight and Investigations Subcommittee. We recently held a hearing about rebuilding the medical infrastructure of New Orleans after Hurricane Katrina. Over and over again, we heard from providers in community health centers about the need for mental health care services. This is particularly true for children, who have lost everything, who are depressed, and in many cases have post-traumatic stress disorder. Yet, while we know the need for mental health care services is severe in the hurricane affected regions, the need is no less acute for some children throughout the country. Many face mental and behavioral health problems, as well as developmental disabilities, that require extensive care—care that they are currently unable to afford. I look forward to hearing from the witnesses on our second panel today about the need to help children with these challenges and ideas about how we can use SCHIP more effectively to address their needs.

Mr. Chairman, reauthorization of SCHIP is certainly of paramount importance during the next several months. However, as we do so we need to make sure that we carefully consider all of the health care needs of those who are and will be covered.

I yield back the balance of my time.

Mr. PALLONE. Thank you, and if I could just mention, as you know, the supplemental has I guess about $730 million for SCHIP for the rest of this fiscal year and the budget that came out of committee has a $50 billion reserve fund for the next 5 years, and when we come back after the break, we will start the process of reauthorizing SCHIP. So I just want all of you to know that we are on top of that, and through all your help, through all the members of the committee.

Dr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

I want to thank my friend from Texas, Mr. Green, for invoking the spirit of Charlie Norwood, certainly the dental conscience of our committee. Charlie was a tireless advocate for improved health care in the United States. He was a tireless advocate for making the system work for everyone for whom it was supposed to work, and Charlie of course was famous for being a straight talker, and in fact today I hope that we can all engage in a little straight talk about this problem because the Maryland case of about a month ago is why we are here today. That tragic story has called attention to the fact that the system failed a family multiple times, and the question before us today is, what do we do about it.

Congress is reauthorizing the SCHIP program and we need to decide in which direction to take the program. Now, certainly we could mandate dental coverage under SCHIP but the fact is that several States already do offer at least some level of dental coverage. Seventy-three percent of federally qualified health centers offer children's dental coverage. So the question is, is that somewhat redundant? Certainly we could allocate more funding to SCHIP but there are some of us who believe that a return on investment for additional funding is sometimes not what we would envision. We could have the Government take over the entire sys-

tem but the Government programs we already have in place face some serious issues.

I would like to refer to a Washington Post article today that quotes a dentist, Aldred Williams. He is the lead dentist at Small Smiles, a district clinic that services Medicaid-qualified children and young adults. His quote is, "There are so many barriers to treating these kids covered by Medicaid including lower reimbursement rates and the bureaucracy. Private practices often end up paying out of pocket to cover the full cost of care." That is why the penetration of private providers in this program are only at about 17 percent. Doctors don't want to see Medicaid patients because they don't get paid fairly and we can't seem to figure out how to pay for all the services we would like to see, so forgive me if I am skeptical that we will improve anything by expanding programs already plagued by irreconcilable systemic problems.

Instead, I believe we should actually address the underlying problems, so I am very interested in the ADA's report on improving access to dental care. I would like to talk about improving Medicaid reimbursement, streamlining the bureaucracy and improving health literacy so that doctors and their patients can navigate the health care system without needing an advanced degree in medical administration or public health policy administration and so that doctors have an incentive to treat indigent patients beyond just the goodness of their hearts. I would like to hear more about the public-private partnership in Michigan and I would like to hear their thoughts on what has made it successful. I would like to hear their ideas for education and prevention so we can encourage Medicaid patients to actually get the care the program covers.

As a physician, I have always tried to make decisions based on what I would want for myself and for my family, and were I homeless and were my family homeless, I would want Medicaid and SCHIP to work and work effectively and work properly but I also wouldn't want to be on it for the rest of my life. I would want the safety net to function as a safety net instead of staying on a minimalist Government program that always falls just short of what was really intended. I would want the knowledge and education that allowed me to navigate the system and make my own appropriate decisions for myself and my children and I would want the power to determine my own fate and the power to change the situation.

Mr. Chairman, you have been very kind in letting me go over but that is what I would be interested in hearing our panel address today, and I will yield back the balance of my time.

Mr. PALLONE. Thank you, Doctor.

I next recognize for an opening statement the gentlewoman from California, Mrs. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Chairman Pallone, and welcome to your children and good testimony to the topic at hand today.

I am very pleased that we are here to discuss the importance of providing children with an early healthy start to their lives. For me it is an issue I have dedicated my whole life to as a public health

nurse, a school nurse, for 20 years and now as a public servant, and I waited a long time ever since being in Congress for this hearing today. We are going to have the opportunity to focus on two areas of health care too often overlooked but so critically important to ensuring the health of children.

Again, I will just mention the name Diamonte Driver, a tragic reminder of our duty to protect and preserve children's health. Unfortunately, there are many Diamontes in classrooms today with abscesses in their teeth across this country. I think it is nothing short of a miracle that more of them don't end up with involving their brain, a stark reminder of the consequences of failing to provide access to preventive health care so cost effective, so important in its results including dental and mental health care. I have been advocating, as I said, for improved children's dental health for years. Children are already vulnerable as a group but children from low-income households are particularly vulnerable. Every school in the country today when a child comes with a swollen jaw and can't eat, can't study, somebody in the school is going to scramble around trying to find some pro bono care, trying to find a provider, and that is health care in our country today. These low-income children are twice as likely to suffer from dental caries than children from higher income families because they are more likely to lack access to dental health care.

In my district, there is a wonderful nonprofit organization that provides a well-run mobile dental clinic to many of the migrant families in my area. Ironically, it is a nonprofit organization designed to provide medical services to Third World countries. They find lots of people to assist right in my backyard.

A few years ago I was honored, it has been mentioned already, to introduce the Children's Dental Health Preservation Act with our late colleague, Charlie Norwood, a bill seeking to identify children at risk for developing cavities as well as to train health care professionals, already been referred to, to educate patients on the importance of preventive health care, dental care, and I think it would be a fitting memorial to our colleague to name this legislation that I hope will result for him. And with SCHIP reauthorization covering the uninsured at the forefront of this committee, I am hopeful we can finally make progress.

Of course, children's mental health is equally as important. Again, I have seen so many children lagging behind their peers because they are not afforded proper treatment or identification of behavior problems which are really mental health issues. Not only are school nurses not equipped to provide comprehensive mental health services, there is a dire shortage of school nurses to identify and refer out and a dire shortage of places for young children to get the kind of treatment that early in life is so effective in changing and responding to this situation.

I hope our witnesses today will help provide us the tools to formulate the kind of policies that will put in place the best models of dental and mental health care for our children, and I yield back.

Mr. PALLONE. Thank you, Mrs. Capps.

I recognize Mr. Murphy of Pennsylvania.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman, and thank you for your leadership on making sure this issue is addressed by this committee and Congress.

We all know in the comments made so far we have talked about how preventive dental care reduces disease and risk before symptoms appear, and I know even in my role as a psychologist, many times kids that I would be seeing, young children we would note as part of their medical concerns that many of them had dental problems that needed to be addressed and so too it was that I worked with families, helping them to search through the bureaucracy to find ways of getting that care. Luckily, there are clinics around for children but many times families are not aware of this and they put off the care and we can see just how bad this can get on something we take for granted that can really lead to infections and to terrible tragedies.

Of course, part of the problem is that many families don't have a medical home and there doesn't seem to be enough available dentists as part of that. I would like to point out that one solution that I have offered is legislation that would help us expand children's access to community health centers and free clinics, community health centers in particular which are nonprofit community-supported health care providers who offer primary and preventive health care services to low-income, underinsured and uninsured families. There are a number of these in the country. Unfortunately, we need many more, but one of the problems is that there is just a vast shortage of many medical providers at these clinics, 10 to 15 to 20 percent shortages of everyone from family physicians, OB/GYNs, pediatricians, et cetera.

Now, one of the things that I know in working with dentists too is that many of them would love to have an opportunity even to volunteer some time. One fellow said to me, if I am going to offer pro bono work, I would like to do it at some other office or clinic where I can do that and give a day or two a month to do that. Unfortunately, the way our bureaucracy is set up, that if someone works at a community health center, they are covered under the Federal Torts Claim Act. If they want to volunteer their time, they are not, and so what they find themselves dealing with is high medical malpractice insurance when all they wanted to do was give some of their time and help children in their community. So I introduced H.R. 1626, which is the Family Health Care Accessibility Act, which extends the Federal Tort Claims Act coverage to volunteer doctors and dentists who want to volunteer at community health centers. I am hoping at some point this committee and subcommittee can take up those issues.

But what is being pointed out, and I look forward to hearing some of the testimony today from the dental association, is just what is this wall of bureaucracy. I hear legends of pages and pages and pages that dentists have to fill out if they even want to work with children, and it comes to the point that the time demands of dealing with the bureaucracy is so much so that they see this as a problem and that is why reading the article in Maryland, there

are only a few hundred dentists out of the thousands which are available who actually work with Medicare.

I look forward to hearing this information today, and again, thank you, Mr. Chairman, for your leadership on this.

Mr. PALLONE. Thank you.

I recognize Mr. Allen of Maine.

OPENING STATEMENT OF HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. ALLEN. Thank you, Mr. Chairman. Thank you for calling this hearing today to examine the critical issue of improving access to dental care and mental health services for America's children.

Dental decay is the most common chronic childhood disease but it is also the most preventable. We know that dental problems can have a profound impact on children's ability to learn and advance in school. It can also hinder their ability to speak and eat. Left untreated, it can lead to chronic disease and even death.

I am pleased to support Chairman Dingell's Children's Health First Act which would expand and significantly increase funding for the SCHIP program. The lack of adequate access to dental care is particularly acute among children from low-income families. Therefore, the bill would require States to offer dental coverage under SCHIP in virtually all cases. It would also require the benefit to mirror the Medicaid early periodic screening, diagnosis and treatment benefit if a State designs its own SCHIP plan rather than simply expanding Medicaid to cover SCHIP children. States would be able to offer SCHIP dental coverage as a wraparound benefit to children who meet the income requirements but who have private medical coverage.

Medicaid patients often don't receive timely dental care because there are not enough dentists participating in the Medicaid program. In rural States like Maine, there is a severe shortage of oral health professionals, particularly pediatric dentists. Maine has approximately 600 dentists but only 278 participate in the Medicaid program. Of these dentists, only nine are pediatric dentists. We need to strengthen the title VII health professions training programs including the pediatric dentistry program. That program provides seed money for startup or expansion of pediatric dentistry residency programs that focus on underserved populations. Investing in children's oral health makes economic sense. For every dollar spent on preventive care, between $8 and $50 can be saved in emergency treatment.

I want to commend the dentists, dental hygienists and other oral health professionals who volunteer their services and give free care to needy individuals, both children and adults. The ADA's Give Kids a Smile Day and innovative State-based public-private partnerships like No Cavities Maine, which reaches children and senior citizens through the YMCA, go a long way to improve access to dental services for low-income individuals. But as one dentist in Maine told me recently, it is not just about 1 day of service or one weekend of volunteering but a daily commitment to provide care for the needy. I want to thank you all for your service.

I look forward to hearing from our distinguished panel on ways we can improve children's access to health care services, and with that, Mr. Chairman, I yield back.

Mr. PALLONE. Thank you.

I recognize Mrs. Wilson of New Mexico.

OPENING STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mrs. WILSON. Thank you, Mr. Chairman. I appreciate your holding this hearing today.

In New Mexico, we have a very serious problem with access to dental care for our population as a whole but particular this is a significant problem with children, and particularly those who are low-income and uninsured in rural areas in Indian country, and it is something we have to address. It is something that I saw as a State official responsible for foster children. Sixty-four percent of third graders in New Mexico have tooth decay and 34 percent have untreated tooth decay. So in a classroom of 30 kids, 10 of them are having problems with their teeth. New Mexico ranks 49th among the States in dentists per capita and we have a similar shortage of dental hygienists. Part of our problem is that 21 percent of our population is eligible for Medicaid. Part of it is that we are a very rural State and it has been difficult to attract dentists to New Mexico. We also in the entire State of New Mexico, the fifth largest by land area State in the country, we do not have a school of dentistry, so New Mexicans who want to become dentists go out of State and oftentimes we never see them come back.

This problem is something I think we need to address systemically, and unfortunately, our State government is not particularly interested in addressing this problem. In the Department of Health, they don't even have a dentist who is focused on oral health.

I appreciate your having this hearing today so that we can look at innovative ways and look at the problem in its entirety of scope. It doesn't matter if you have insurance or it is included under Medicaid if you can't find a dentist or if the dentist you can find won't take Medicaid because the bureaucracy and the paperwork is such a terrible nightmare. We need to address these problems so that kids get access to care no matter where they live.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

I recognize next Ms. Solis of California.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Mr. Chairman, and I want to also applaud you for having this very important hearing this morning.

Oral health is closely linked to overall physical health and I believe oral health has to be a big priority for us both at the local level, the State level and the Federal level and that is why I am glad we are having the hearing today.

The California Oral Health Needs Assessment revealed that three out of every 10 Californian third graders had untreated tooth decay. These numbers are particularly troublesome for children in minority and underrepresented communities. Latinos along with African-Americans and Native Americans have the poorest dental health of any racial group in the United States, and in California, the State that I represent, Latino kindergarteners were 2.4 times more likely to have untreated tooth decay than white children. Their oral health dramatically affects their ability to lead active lives. For example, Latino children are more likely to miss school due to oral health problems, and we are all aware of the problems associated with the lack of medical insurance yet the situation for dental coverage is equally important. For every child who lacks health insurance, approximately three children lack dental health care. In California, 25 percent of our children lack dental insurance, which decreases the likelihood that they will receive regular checkups and treatment. Low reimbursement rates add to the problem for programs like Denti-Cal, the California dental Medicaid program, and the lack of providers willing to take on Medicaid patients also poses a major obstacle to accessing dental care, and more and more families are unable to afford health insurance. Many of our children do not receive the proper health and dental care they deserve, and I hope that through SCHIP and Medicaid we will address the critical need for dental services and improve dental coverage overall. We must work closely with our schools and with our public health clinics to expand care so that our families are all served.

In my district in California, the 32d, I worked very hard to partner with L.A. Unified in one of our middle schools to provide a dental clinic there to help provide wraparound services, mental health services and daily checkups, not just for the students attending the school but the outlying community that could also benefit from that help. I am also proud to say that one of our local clinics that was just reopened in the city of Azusa in L.A. County is now beginning to look at offering dental services for residents in Azusa who are primarily Latino, about 70 to 80 percent, and have incomes below $30,000.

So I am pleased that we are having this discussion and debate and I also want to mention that the Congressional Hispanic Caucus, as task force chair during the past few years we were able to work closely with Univision, one of the major Spanish language networks, to create public awareness programs in Spanish to provide briefings and better understanding about dental care and we did it in conjunction with the dental association. So I want to thank them for that. I look forward to your testimony today and look forward to seeing the expansion of dental care services for our children.

Thank you. I yield back the balance.

Mr. PALLONE. Thank you.

I now recognize Ms. Hooley of Oregon.

OPENING STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Ms. HOOLEY. Thank you, Mr. Chairman.

Like my colleagues, I was shocked and deeply saddened to hear about the death of 12-year-old Diamonte Driver. The death of a child is always a terrible event. However, Diamonte's passing is particularly distressing because we know that his death could easily have been prevented with low-cost dental care. Most Americans including myself were shocked that a child could die in the United States for want of such a basic dental service.

While we should shine a light on the heart wrenching tragedy of Diamonte's death, it is also important to remember that poor oral health has other consequences that are less severe but still detrimental to a child's well-being. As a former schoolteacher, I can attest to the fact that a child's toothache can have a very disruptive effect on the learning process. Not only is the child in pain, unable to learn, but a child in pain is often a disruptive force that hampers the ability of other children to focus and participate in class. That challenge to effective learning is unfortunately only part of the overall harm. In addition, more than 850,000 school days each year are missed by students because of dental-related illness. A child who is not in class obviously cannot learn. At a time when there is a strong emphasis on student achievement, I hope we can take an expansive view of what impacts learning. I think oral health is one of those factors that should get a lot more attention.

The mental health problems of children often similarly do not receive the focus that they warrant. Again from my years as a teacher, I know that there is nothing more frustrating than seeing a child struggle who could flourish if he or she received appropriate mental health services. I look forward to discussing access issues resulting from the lack of mental health providers or too few participating providers.

Mr. Chairman, again I thank you for holding this hearing on these very important but often unappreciated issues. Thank you.

I yield back.

Mr. PALLONE. Thank you.

The gentleman from Utah, Mr. Matheson.

OPENING STATEMENT OF HON. JIM MATHESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. MATHESON. Thank you, Mr. Chairman. Thank you for holding this hearing today. It is an issue that is very important to our national health care debate. Although I am saddened by the events that have brought us together, I feel we have an opportunity to honor the memories of these two boys by examining how our Nation's uninsured children are accessing dental care.

In my State, children without dental insurance receive most of their services in safety-net clinics such as community health centers, donated dental services and primary children's medical centers. We have a program called the Utah Oral Health Program and it has completed an oral health survey of 6- to 8-year-old children in the fall of 2005. Of those surveyed, 25 percent indicated they had no dental insurance, 20 percent indicated they had not seen a dentist in the past year, and 10 percent indicated they needed dental care in the past year but could not get it. Of those surveyed, 21 percent had obvious dental decay. These are troubling statistics and ones that we are working hard to address.

In an effort to educate Utahans on the importance and far-reaching impact of preventive dental care for children, we have been proactively promoting preventive oral health care throughout the State in a number of ways. For example, the statewide campaign by the Utah Dental Association emphasized the importance of the early diagnosis of oral cancer. The Baby Your Baby campaign includes information on the relationship between periodontal disease and low birth weight pre-term births. In addition to the oral health program, the Utah Dental Association and the Utah Dental Hygienists Association have completed several activities throughout the State to promote the first dental visit for children by age 1 or within 6 months of the first tooth erupting. Outreach to Utahans has included visits to local dental societies, presentations to local health departments, presentations to conferences, newsletter articles and brochures. That is a quick list of the outreach we try to do in our State.

I mentioned to this committee before that my wife is a pediatric infectious disease doctor at the Primary Children's Medical Center in Salt Lake. I have heard very much around the dinner table stories about the importance of preventive care in terms of oral health. Access to care is such a critical issue for our country. I look forward to hearing the suggestions of the committee and the witnesses on identifying responsible ways to improve access to dental care for our kids.

Mr. Chairman, I will yield back.

Mr. PALLONE. Thank you.

Next is the gentleman from New York, Mr. Towns.

OPENING STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. TOWNS. Thank you very much, Mr. Chairman, for holding this hearing. I think this is a very important hearing.

Eighty percent of all tooth decay is found in 25 percent of children. Despite the magnitude of need, dental coverage remains an optional benefit in SCHIP. All States have recognized that poor oral health affects children's general health and have opted to make dental coverage an option. However, dental coverage is often the first benefit cut when States seek budgetary savings. I believe that Congress must stabilize access to dental care for children by establishing a Federal guarantee for dental coverage in SCHIP.

In addition, the National Dental Association and the National Dental Hygienists Association, which represents African-American dentists and dental hygienists, believe we must substantially increase the number of minorities entering the field of dentistry and other allied oral health fields if we are to turn around the tragedy related to underserved communities and oral health.

It is also time we stopped punishing parents with moderate incomes whose children receive medical, but not dental, benefits through employer-sponsored health plans. Many of these parents and their children cannot afford dental coverage. We need to develop a dental wraparound benefit in SCHIP that allows these parents to purchase dental insurance if they meet other eligibility standards. It is time we commit ourselves to quality dental care for

all because it is less expensive to prevent advanced oral problems than to deal with them in an emergency room. I think Dr. Ellerman is right when she said that we must now begin to think of our children. They are 25 percent of the population but 100 percent of our future. I am sure that our witnesses this morning will be able to shed some light on the issue of dental care under SCHIP and that we will be able to do a much better job on behalf of our children.

On that note, Mr. Chairman, I yield back.

Mr. PALLONE. Thank you.

And our other gentleman from New York, Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman. When you said the gentleman from New York for Mr. Towns, I started to push my button.

Mr. TOWNS. It would have been OK.

OPENING STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. ENGEL. But I agree with everything Mr. Towns said, and I want to thank you for holding this hearing. It shouldn't take a tragedy to call attention to the need for comprehensive accessible health care but that certainly is what the senseless death of Diamonte Driver has done this month, a 12-year-old who died of a brain infection initially caused by an infected tooth and had been covered by Medicaid, which would have covered his health problems. A series of events led to the loss of his coverage though, which certainly highlights the need for presumptive eligibility. A simple dental procedure that could have cost $80 to cover went untreated and manifested in a serious brain injury requiring nearly a quarter of a million dollars in care which ultimately could not save this child.

Considering that dental care is the most prevalent unmet health need among American children, and that is a quote according to the U.S. Surgeon General, it simply makes sense to shore up our public programs that provide dental care to low-income children. While the Medicaid program provides comprehensive coverage for children's dental care through the Early Periodic Screening Detection and Treatment benefit, access to care is hampered by low Medicaid reimbursement rates. States that can compensate dental care providers with rates closer to market-based fees have been able to enroll more providers in the Medicaid program and in turn successfully treat more children. The SCHIP program by contrast does not even require that children be entitled to dental care. While all States have elected to provide some coverage, the benefits and access to treatment varies widely from State to State. As we move to authorize the SCHIP program, I believe we should modernize it to establish a Federal guarantee for dental coverage. We should also strongly consider developing a dental wraparound benefit in SCHIP to support families with low to moderate incomes covered in the private market who do not receive dental coverage for their children.

Mr. Chairman, while all the witnesses on the two panels are impressive, I would like to extend a warm welcome to Dr. Edelstein of the Children's Dental Health Project and Columbia University in

New York City, where I am from. The Columbia University teaching clinic offers outstanding primary and specialty oral health care at reduced cost to patients. At the onsite dental clinic, general oral health and specialty practitioners handle more than 80,000 patient visits each year. It is a great service to the community and I commend Columbia for this work.

Mr. Chairman, there is no question that well-child care should include comprehensive dental care. I am pleased that you have convened this hearing to discuss these important issues and look forward to the witnesses' testimony today, and I yield back the balance of my time.

Mr. PALLONE. Thank you.

That concludes the opening statements by members of the subcommittee, and I would ask unanimous consent any other statements be included in the record at this time.

[The prepared statements follow:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Today's hearing will focus on providing a healthy start for children. It is common sense that keeping children healthy and treating illness early is a wise investment. Children who are healthy do better in school. They are at lower risk for developmental problems. And their future healthcare costs are likely to be less.

Medicaid and the State Children's Health Insurance Program (S-CHIP) provide the health insurance and a healthy start for nearly a quarter of U.S. children. These two programs are primarily responsible for preventing these children from joining the increasing number of those who are uninsured. Our Nation has made good progress in getting children immunized against disease, but progress has been slower on dental care and mental health care. Clearly more needs to be done.

Medicaid's coverage of dental and mental health benefits is exemplary. And many States meet Medicaid's standard of coverage under SCHIP, as well. But many do not. And that means many children still have unmet needs in these two areas.

Dental disease is the most common childhood disease—more prevalent than asthma and diabetes. It is also the most easily prevented. Proper care, however, must start in infancy, including oral checkups, preventive care, sealants, fluoride, and at home oral care.

If left untreated, however, dental disease can be deadly. Sadly, the Nation learned this recently from the much-publicized case of a 12-year-old child from Maryland named Deamonte Driver. In Mississippi, there was recently an equally tragic and equally preventable death that would have been prevented if action had been taken sooner. Six-year-old Alexander Callendar died due to untreated dental disease.

The need for action exists on several levels. The Congress has a role to play in ensuring States have sufficient resources in Medicaid and SCHIP to address the unmet dental need among children. The Federal Government needs take steps to prevent future tragedies from occurring. We need to play a role in training and education of dentists. And we have a role to play in ensuring access in all communities.

I will soon introduce a bipartisan bill that will move us forward toward addressing many of these issues. I hope that my colleagues on the committee will join me in cosponsoring this legislation. It should be a national priority.

Likewise, children's mental health care is also a significant challenge for families, especially the uninsured or under-insured. Private insurance coverage is limited or inadequate for those with the greatest need. Under Medicaid and SCHIP we need to do more to make community-based mental health care an option. There are more than 12,000 children across the country who are on waiting lists because existing programs lack space. In addition, the Centers for Medicare and Medicaid Services (CMS) has recently initiated efforts that would restrict or even eliminate States' ability to manage the care of children with the most severe mental illnesses. We need to be assisting children and States in this area, not further restricting access for children to receive needed care. CMS's actions are unacceptable and this is something we will explore in the near future.

I thank Chairman Pallone for this hearing. It is timely. It is necessary. I look forward to working with my colleagues on these important health priorities.

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman, for holding this hearing on the role of early health care interventions to ensure that children have a chance for a healthy start in life. Two health care benefits most often overlooked are dental and mental health care.

Tooth decay is the most common childhood disease, affecting five times more children than asthma, and seven times more children than hay fever. In February and March of 2007, untreated dental problems caused the deaths of two children in Mississippi and Maryland. Had these children had access to preventive dental care, they would be alive today.

Mental health care is also an important benefit for children. The Urban Institute estimates that at least one-tenth of children suffer from a serious mental health problem that causes impairment. Poor children have more mental health problems than other children, yet they have fewer options for mental health screening and care.

Programs like Medicaid and the State Children's Health Insurance Program (SCHIP) play an important role in providing preventive health services to low-income children. Medicaid is widely considered the largest provider of funds for mental health services for children and it also provides comprehensive coverage for children's dental care needs. However, due to differences in how States operate their SCHIP programs, access to mental health and dental care benefits vary geographically.

Childhood is the most important time in a person's life for preventive screening and treatment of mental and physical ailments. We must assure that children and their families have access to resources and services that promote positive early health and development.

I urge my colleagues on this subcommittee and in Congress to ensure that children have access to important, preventive health care which includes comprehensive dental and mental health benefits. We can do this by including these benefits in our reauthorization of the State Children's Health Insurance Program later this year.

Thank you, Mr. Chairman, and I look forward to hearing the testimony of our expert witnesses.

Mr. PALLONE. I will now turn to our witnesses, and our first panel is already there. I want to welcome you again. Let me introduce each of you, starting from my left to right. First we have Dr. Burton Edelstein, who is founding director of the Children's Dental Health Project. Second, we have Dr. Kathleen Roth, who is president of the American Dental Association. And then we have Mr. Raymond Scheppach, who is the executive director of the National Governors Association, and then we have Christine Farrell, who is the Medicaid policy specialist with the Michigan Department of Community Health, Medical Services Administration. And next is Dr. Nicholas Mosca, who is clinical professor of pediatric and public health dentistry at the University of Mississippi School of Dentistry, and last is Dr. Stephen Corbin, who is senior vice president of Constituent services and support for the Special Olympics International.

Thank you again for being here. We are going to have 5-minute opening statements from each of you. Those statements will be made part of the hearing record and each witness may in the discretion of the committee submit additional briefs and pertinent statements in writing for inclusion in the record. And I will start, again from my left, and recognize Dr. Edelstein for an opening statement.

STATEMENT OF BURTON L. EDELSTEIN, D.D.S., M.P.H., FOUNDING DIRECTOR, CHILDREN'S DENTAL HEALTH PROJECT

Dr. EDELSTEIN. Thank you, Mr. Pallone.

My name is Burton Edelstein. I am a pediatric dentist who has been involved with dental coverage for poor and low-income children as a student, clinician, educator, researcher and policy analyst for 37 years, nearly as long as the Medicaid EPSDT benefit that so many of you mentioned. I speak to you today as founding director of Children's Dental Health Project, a DC-based nonprofit policy organization committed to improving children's oral health in America. My testimony has also been endorsed by my professional association, the American Academy of Pediatric Dentistry.

The committee has shown a strong command of the issue and has so well described the problem. I seek today to pull much of what you said together and make some recommendations for solutions. I thank the committee for addressing children's oral health, an issue highlighted tragically by the death of Diamonte Driver that has been noted. I dedicated my testimony today to him but also to the hundreds of thousands of other children who suffer significantly and unnecessarily from completely preventable dental problems.

My testimony is grounded in three straightforward facts. First, that tooth decay is virtually preventable, almost completely preventable, yet ironically, as you note, it remains the single-most common chronic disease of childhood in the United States and is present in one-quarter of all 2- to 5-year-olds. Second, dental care is essential to overall health, yet for reasons that make neither biologic sense nor policy sense, dental care has been legislated as an optional service as though the mouth were not integral to the body. Third, preventive care is cost-effective yet far few children obtain the kinds of routine care that would prevent pain, infection, sleepless nights, missed meals and poor school performance that you have noted.

Medicaid itself, as envisioned by Congress, is tremendously valuable. It is appropriately designed and it is fully accountable. In the handful of States that have taken their dental Medicaid programs seriously and reformed them well, Medicaid has been shown to work for dentists, for children, for families, and the number of dentists participating has increased dramatically, twofold, threefold, fourfold. These States have been creative and they have taken advantage of flexibility that already exists in the program. But in too many States, there has not been attention to the opportunities in Medicaid and the programs have been allowed to fail, fail children and fail the providers who care for them. Congress can play a stronger role in assuring that Medicaid works for all children across the country by helping States, by enhancing your oversight, by providing grants to support State program improvements, by offering technical assistance, by promoting best practices and by holding States accountable for the performance that is already required by Medicaid law.

SCHIP is a different story. It is now 10 years old and due up for reauthorization, which provides a terrific opportunity for Congress to do many of those things that you spoke of. With the three recommendations that I make now, I am speaking for 12 national dental membership organizations including all of those present at this table as well as organizations of pediatric and general dentists, Hispanic and black dentists, dental hygienists, dental researchers,

State dental officers and dental students. Together we ask you to do three things with SCHIP.

Firstly, put the mouth back into well-child care. Recognize with us that the mouth is integral to the body and that dental care cannot be considered an optional service, and because States are already significantly involved in providing dental care, this can occur at very little cost. Second, allow States to offer that wraparound dental coverage that some of you have mentioned. This will incentivize poor and working-class families to retain their private medical coverage and not drop it so that they obtain their medical and dental coverage together through SCHIP. And third, require States to report on their dental program performance in SCHIP. After 10 years, we know almost nothing about the performance of SCHIP for dental coverage while we know a great deal in Medicaid. Similar reporting in SCHIP would help you and help children gain the benefit that they already have available to them.

With these few Medicaid and SCHIP fixes, the benefit of cost-effective prevention can bring savings to Government and better health to children. This is unusual, to be able to have both better health and cost savings at the same time. For example, Diamonte could have received preventive care for 12 years. He could have had a sealant. He could have had a filling. He could have had a root canal. He could have had a number of dental treatments, no one of which would have cost more than one one-thousandth of what his hospital stay cost.

The problem of childhood tooth decay is also global. The U.S. has recently joined with other nations representing half of the world's population to eliminate childhood dental caries. Unlike most of the partner nations, the U.S. has no Federal entity that coordinates and integrates the various programs across its agencies. We in the U.S. would benefit greatly if Congress were to charge the Department of Health and Human Services to develop an interagency taskforce on children's oral health with strong leadership and strong Congressional support. In this way, the U.S. could set the international standard for children's oral health.

On behalf of America's children, I urge you and the committee to continue attending to pediatric oral health, to continue beyond this hearing, to maximize opportunities for cost-effective prevention, to ensure that dental care is never again considered an optional service as though it didn't matter, and to integrate oral health into each and every Federal program that addresses children's health and well-being. Diamonte is sadly only one example of what happens when we fail as a nation to sustain attention to children's oral health. The problem with childhood oral health is fixable and fixable at low cost. Let us work together to enhance Medicaid and SCHIP, to do more to educate the public, to improve training of dental professionals and to care for young children for the benefit of prevention for all.

Thank you so much.

[The prepared statement of Dr. Edelstein follows:]

TESTIMONY OF BURTON L. EDELSTEIN, D.D.S.

Good morning. My name is Burton Edelstein. I am a pediatric dentist who first cared for a child with Medicaid coverage 37 years ago—just 3 years after Congress

mandated dental services for children in Medicaid. Since that time I have been actively engaged in Medicaid and SCHIP as a private practice clinician in Connecticut, as a dental educator now at Columbia University, and as founder of the Children's Dental Health Project—a DC-based independent policy organization committed to improving children's oral health in America.

I have learned about publicly financed dental coverage from my patients and their families, from students and colleagues, and from working with Congress and the Department of Health and Human Services. I have also observed much from the public's response to the tragic and completely avoidable death of Deamonte Driver, the Maryland 12 year old who died just up North Capitol Street from here at National Children's Medical Center from complications of a dental infection. Sadly, Deamonte represents the worst case scenario of multiple systems failures. I dedicate my testimony to him and to the hundreds of thousands of other children who suffer significantly and unnecessarily from preventable dental problems.

My testimony today reflects the totality of this experience. It is based on three facts:

- first, that tooth decay is overwhelmingly preventable;
- second, that dental care is essential to children's overall health and wellbeing; and
- third, that dental care is cost effective.

All three qualities have strong implications for the committee's oversight of Medicaid and the State Child Health Insurance Program.

Regarding Medicaid: Medicaid dental coverage for children as envisioned by Congress is tremendously valuable, appropriately designed, and fully accountable. The handful of States that have implemented Medicaid dental coverage well have demonstrated that this program works for children, their families, and their caregivers. But in the majority of States, Medicaid dental coverage is little more than an unfulfilled promise—adequate coverage but inadequate services. Congress has many options to further strengthen dental Medicaid performance across the Nation through improved oversight; incentives and sanctions, Federal grants to States for program improvements, and beneficiary empowerment by granting legal standing to beneficiaries when the program fails them.

Regarding SCHIP: In the aftermath of Deamonte's death which so clearly demonstrated that the teeth and mouth are an integral part of the body, dental coverage can no longer be considered an "optional service" in SCHIP. Just as the mouth is integral to the body, so too must dental care be legislated as an integral component of well baby and well child care. With SCHIP reauthorization now underway, Congress can take steps to stabilize and improve dental coverage in SCHIP by requiring that it provides both dental preventive and dental treatment services. Congress can enact "wrap around" dental coverage in SCHIP for those children from working-poor families who have medical but no dental coverage and it can require dental performance information from States so that they are accountable to both the Federal Government and to the children.

The fact that dental care is prevention oriented, essential to children's health, and cost effective also makes it a very favorable healthcare service from a public insurance perspective. A small upfront investment in comprehensive dental care for all children would pay considerable dividends in both health outcome and dollars saved. But effective preventive dental care requires that children receive care early and periodically in a dental home—an identified source of ongoing care that provides complete oversight and care coordination for each child. For example, if Deamonte Driver had had a dental home starting with the recommended age-one dental visit, his disease may well have been prevented through health education and counseling, fluoride treatments, and placement of dental sealants. Had this level of treatment been insufficient and he still developed cavities, they would have been found early and treated at low cost. Rather than a quarter million dollar bill to Maryland Medicaid for neurosurgery, he could have been treated with a sealant, a filling, or, if necessary, an extraction—any one of which would cost the State less than $150.

Dental disease matters: Ordinary tooth decay needs no longer be the single most common chronic disease of childhood in America. As a nation, we can reach our elusive Healthy People 2010 goals for children's oral health and can reverse the recent upswing in tooth decay reported by CDC for our youngest children. CDC reported in August 2005 that more than a quarter (28 percent) of 2–5 year olds already have cavities in their baby teeth and half (49 percent) of children ages 6–11 have cavities in their adult teeth. Toothaches that distract from eating, sleeping, and attending to schoolwork are completely preventable and—when they do occur—are completely treatable at low cost. Dental abscesses that lead to swollen faces like that shown in the photograph before you, and even to head and neck infections that can proceed

to cause significant morbidity and occasional mortality are similarly avoidable—and when they occur—treatable at low cost. Yet many children insured through Medicaid seek relief of toothaches in the emergency rooms of our community hospitals because of difficulty accessing dental care in private and safety-net offices. One Texas study reported that the cost to Medicaid is three times greater for emergency room care—care that doesn't solve the underlying dental problem—than the total cost of preventive care would have been to assure oral health in the first place [1]

Dental coverage matters. Federal data confirm that children with dental coverage, whether in Medicaid, SCHIP, or employer-based insurance, obtain more dental care than similarly situated children without coverage. Yet Medicaid and SCHIP have not realized their full potential in most States as far fewer children in these programs are able to access care than children in commercial coverage. According to the most recently available CMS data on Medicaid program performance, only 30 percent of children enrolled in Medicaid at any time during the year had at least one dental visit and only 25 percent had at least one preventive dental visit—less than half the rate of services obtained by commercially insured children. State-by-State performance varies greatly—ranging as low as 13 percent in one State to as high as 47 percent in another. We know far less about SCHIP effectiveness because Congress has not to date required systematic dental performance reporting in SCHIP.

Effective Medicaid and SCHIP dental coverage matters. According to a HRSA report, young children in poor and working poor families (<200 percent FPL) eligible for Medicaid and SCHIP are five times more likely to have cavities than children in higher income families (>300 percent FPL). They have three times more teeth decayed and are twice as likely to seek a dental visit for pain relief—but are only half as likely to obtain a dental visit in a year. These disparities can be well addressed by effective SCHIP and Medicaid administration in the States and by working collaboratively with families, dentists, and government to ensure that the program meets diverse needs and constraints.

Prevention matters: CDC promotes prevention programs including community water fluoridation that continues to effectively dampen decay experience in America and sealant programs that protect permanent teeth that are most susceptible to decay—like the tooth that ultimately led to Deamonte's demise. The Maternal and Child Health Bureau's focus on the oral health of young children in Head Start and on children with special health care needs promotes early and timely prevention. NIH-sponsored research over the past 40 years has well established that tooth decay is an infectious disease that is typically transmitted from mothers to children during a child's first years of life. This and other scientific knowledge about the nature of the disease provide a number of options for "providing a healthy start" for all children through universal acceptance of the age-one dental visit, parent and provider education, and regular dental care in a dental home. Lacking only in these Federal programs is sufficient support, coordination, and dissemination of best practices to realize tremendous financial and health returns for our children.

Global perspective: Childhood tooth decay is a global problem. Pediatric oral health activists in the US from inside and outside of Federal Government have recently engaged in a global campaign to reduce childhood tooth decay through both prevention and treatment approaches. With sufficient ongoing Congressional attention to dental care for our children—particularly for those who are eligible for Medicaid and SCHIP—the US can set the standard of good oral health for children and can become the international leader among the 11 participating nations that represent half of the world's child population.

On behalf of America's children, I urge you and your committee to continue attending to pediatric oral health, to maximize opportunities for cost-effective cavity prevention, to ensure that dental care is never again considered optional in SCHIP, and to integrate oral health into each and every Federal program that addresses the health and welfare of our Nation's children. You have before you many policy options and opportunities for "improving access to dental care and providing a healthy start for children." My colleagues and I look forward to your questions today and to providing ongoing assistance in your efforts to ensure "bright futures" for all children.

Thank you.

Mr. PALLONE. Thank you, Doctor.

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1 Pettinato ES, Webb MD, Seale NS. A comparison of Medicaid reimbursement for non definitive pediatric dental treatment in the emergency room versus periodic preventive care. Pediatric Dentistry, 2000

I am going to ask Dr. Roth to speak next. I know that it is hard to keep to the 5 minutes, but if you can, I would appreciate it because we do have a lot of people. Thank you.

STATEMENT OF KATHLEEN ROTH, D.D.S., PRESIDENT, AMERICAN DENTAL ASSOCIATION

Dr. ROTH. Yes. Good morning, Mr. Chairman and members of the subcommittee. I am Kathleen Roth from Wisconsin, a practicing dentist and currently the president of the American Dental Association. I have participated in Medicaid and SCHIP. I have firsthand knowledge of providing care to those underserved children so severely in need of dental care and I understand the havoc that no care can really cause in a child's mouth.

Like all of us, I was very shocked at the death of 12-year-old Diamonte Driver, who lived just a short distance from here. I believe that we have an obligation to honor this child and his family by saying no more: no more children unable to eat and sleep properly, no more needless deaths, no more unable to pay attention in school and no more unable to smile because of severe dental disease that could so easily be prevented and treated. If we do not resolve to reform the system now, we are ignoring the warning that this tragedy is sending us and the Nation's children will continue to suffer the consequences. It is not just the poor that are affected. As you will hear from Dr. Corbin in his descriptions, mentally disabled children and adults also face severe barriers to receiving oral health care.

I have provided care to the underserved in my community for many years. Every dentist I know provides some free or discounted care to people who need it and otherwise would not be able to get it. We do this both individually and collaboratively. One study published in the mid–1990's estimated that dentists deliver $1.6 billion in free or discount care in a single year, but the sad fact is that all of our volunteerism and charitable efforts are not enough and they never will be enough because charity is not a healthcare system.

Wisconsin is an all-too-typical example of how the so-called safety net is anything but. The Badger Care reimbursement schedule is so meager that in most cases it does not even cover dentist overhead. The paperwork is onerous and confusing. The entire process is actually so frustrating that it discourages dentists from participating in the program at all.

It is critical that we build a preventive infrastructure that ultimately will be the only way that we will end what the former surgeon general, David Satcher, famously titled the silent epidemic. To that end, every child should see a dentist within 6 months of the appearance of that first tooth and certainly no later than the first birthday. We need more community-based initiatives such as water fluoridation and the broader availability of dental sealants and topical fluorides.

We must embrace innovations in the dental workforce. The ADA has modeled a new type of an allied dental provider, the community dental health coordinator, which will greatly enhance the productivity of a dental team by extending our reach into underserved communities. The CDHC model is unique in that it combines the

provision of preventive services along with triage, case management and referral to qualified dentists when care is needed.

Ninety percent of the Nation's dentists are in private practice. We need to make it possible for more of them, many more of them, to participate in Medicaid. Several States have refined their Medicaid programs to do that. You will hear about Michigan's program in a moment. Tennessee has reformed TennCare, and Smile Alabama is an excellent example. In some cases programs have succeeded in enrolling Medicaid beneficiaries into existing and very well-designed private sector dental plans. Congress can do a great deal to encourage and make it possible for more States and communities to take similar measures through grants and other means. Chairman Dingell has been a leader in this area and working with Congressman Mike Simpson, who is also a dentist, as well as many of you members on this committee who are sponsoring the Children's Dental Health Improvement Act.

Mr. Chairman, the most vulnerable amongst us, especially the children, deserve much better, better than the fate that befell Diamonte Driver, and better than the untold numbers of children, someone within a few blocks of where we are today, who are suffering from untreated dental disease. Dentists can do more but only if the State and Federal Governments will give us the support that we need to do that. We call upon our many friends here in Congress to work with us to ensure that every American child can face his or her future with a smile.

Thank you.

[The prepared statement of Dr. Roth follows:]

Statement of Kathleen Roth
President, American Dental Association

My name is Kathleen Roth, president of the American Dental Association (ADA). I am a practicing dentist in West Bend, Wisconsin, and a Medicaid provider. I also participate in Wisconsin's State Children's Health Insurance Program (SCHIP). Chairman Pallone and members of the subcommittee, the 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. On behalf of the American Dental Association I extend my 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 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

[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/
[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.

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 more effectively address the special needs of underserved communities, especially children, and have endorsed the development of a new member of the dental team – the Community Dental Health Coordinator (CDHC) – to help address those needs. 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. CDHCs will be competent in developing and implementing community-based oral health prevention and promotion programs; providing 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.

Congress must continue to fund crucial federal oral health care access programs. The ADA and the larger dental community have for years worked to ensure there was 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 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 properly support these vital programs as part of our collective effort to fix the access problems for children from low-income families and other underserved.

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[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.

[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.

The ADA is also very pleased that the House companion bill to S. 739, the "Children's Dental Health Improvement Act 2007," that will be cosponsored by Representatives Dingell and Simpson, will soon be introduced. That 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 centers with another option to efficiently provide dental services 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 has for many years 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

[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.

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 should 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 also has a number of initiatives it is undertaking 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 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 all practicing 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,

[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.
[12] DHHS, HRSA, BPHC, 2005 Uniform Data System.

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, which also 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

[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.
[17] General Accounting Office, "Oral Health … Factors Contributing to Low Use of Dental Services by Low-Income Populations," September 2000. p.4.

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 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

[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.
[21] Ibid.
[22] American Dental Association, "State and Community Models for Improving Access to Dental Care for the Underserved," Executive Summary, October 2004.

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 program in 2002, whereby the dental care was administered by its own benefits manager and had its own funding stream, comprising 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

[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"

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.

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

[26] Smile Alabama! "Alabama Medicaid's Dental Outreach Initiative."

development of Community Dental Health Coordinators, who could greatly enhanced the productivity of our dental teams in the future and will bring the expertise needed to efficiently 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 Medicaid programs through grants and other means.

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.

Mr. PALLONE. Thank you, Dr. Roth.

And next we have Mr. Raymond Scheppach.

STATEMENT OF RAYMOND C. SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION

Mr. SCHEPPACH. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you on behalf of the Nation's Governors.

I would essentially like to focus on three major issues. First, what States are currently doing to extend dental health benefits to children; second, how any particular benefit in SCHIP or Medicaid relate to new State reform initiatives; and three, I think it is important to be aware of State Medicaid spending and how it is related to other priorities like education.

Since the enactment of the State Children's Health Care Program in 1997, there has been a substantial expansion of dental services. While this is an optional benefit, all States have provided some dental benefits. Currently the enhanced match and increased flexibility to tailor benefits has contributed to the overall success of this program.

SCHIP and Medicaid dental benefits are important, but having benefits does not necessarily mean that individuals receive services. This is particularly true, given the shortage of dentists in many areas, and more importantly, the more acute shortage of pediatric dentists, especially those trained to provide services to children with special health care needs. Therefore, States have taken a more holistic approach to this problem. First, they have been doing a fair amount in terms of promoting education and prevention, in terms of PSAs, public awareness, working with communities on fluoridation. They have also tended to increase coverage and access at times working with States like Michigan and with network providers. They have also focused to some extent on enhancing the dental workforce, trying to provide special incentives for underserved areas, also providing tax credits, loan forgiveness for the education of dentists and improving finance through increasing reimbursements. Investments in children's health are extremely important but Governors are also well aware of the need to look holistically at making investments in children's futures. This is especially true in the area of early childhood development.

I would like to turn now and summarize very quickly, Mr. Chairman, some of the things that are happening at the State level in terms of health care reform. In 2003, the State of Maine enacted a comprehensive proposal with the goal of universal coverage by 2009. This was quickly followed by Vermont and Massachusetts, who enacted plans in 2006 with the ambitious goals to cover all of the insured. There are now about four States who have committed to universal coverage while another 10 are developing proposals for universal access. Several others are focused on universal care for children and many others are pursuing more incremental reforms. There is a number of common elements in all of these reforms. They obviously include coverage expansions. They include connectors, essentially trying to bring together providers with low-income individuals to provide the best appropriate benefits and allowing choice and portability. They have worked on the so-called tax incentives, making sure everybody is aware of section 125. States are

experimenting with both employer mandates in terms of where is the cutoff in terms of small business. They are experimenting with individual mandates also with quality improvements and measurements. They are also negotiating with providers to increase a number of affordable benefit packages.

Mr. Chairman, I think we are at the point now where it is very possible over the next 2 to 3 years that we may witness as many as eight or ten States who have actually enacted and begun to implement universal care or universal access, and I think as you move forward on the reauthorization of SCHIP and other programs, you have got to question how that fits in with essentially what is happening at the State level.

I would just a raise a couple of potential cautions as you move forward with respect to any mandates on SCHIP or Medicaid. First, it would require States to spend more money per person on these programs which redirects funds from eligible expansions. I think if we continue to have 47 million uninsured, it is a real public policy question of whether we create a more robust benefit package for some or whether we try to get a basic benefit package for a wider population.

Second of all, it could limit State efforts to create affordable consolidated insurance markets. Most States' coverage efforts include negotiations with providers to develop basic benefit packages that would be subsidized for States and offered through a connector. Essentially what the connector does is, it consolidates the individual and the small group markets into a pool. It then matches providers by offering benefits with the demand for health care for State employees, SCHIP, Medicaid as well as small business. This approach reduces risk, lowers costs, stabilizes the small market, essentially mandates that changes to benefits packages could become an obstacle to the efficiencies of these pools. Rather than allow Federal programs to be integrated into the overall health care system, SCHIP and Medicaid may well continue to be separate, more expensive programs.

I would just like to end with a few comments on Medicaid and State budgets. Unfortunately, Medicaid has grown about 11 percent per year over the last 25 years. It is now almost 23 percent of State budgets. It is more than all elementary and secondary education. In some States, it is 34, 35 percent. With State revenues growing only 5 to 6 percent, Medicaid has been funded by cutting virtually all other components of State spending.

Mr. PALLONE. I know you said you are wrapping up but you have already gone over a minute, so——

Mr. SCHEPPACH. Let me just say that we have two challenges, it seems, universal health care and overall competitiveness. States are trying to make the balance between education commitments and health care.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Scheppach follows:]

STATEMENT OF RAYMOND C. SCHEPPACH

Mr. Chairman: I appreciate the opportunity to appear before you today to discuss the issue of dental health as it relates to Medicaid and S-CHIP. It is important to

continue to evaluate the structure of benefits for both of these programs and how they relate to health care reform in general.

This morning I would like to focus on three major issues as follows.

First, what States are currently doing to extend dental health benefits to children and how this benefit relates to other early childhood services. Second, since there is essentially an explosion of health care reform activity in the States, is important to evaluate how any particular benefit mandate relates to these new reform initiatives. Third, it is important to be aware of State Medicaid spending and how it is related to other State priorities such as education.

DENTAL HEALTH AND EARLY CHILDHOOD

Since the enactment of the State Children's Health Insurance Program (S-CHIP) in 1997, there has been a substantial expansion of dental services. While this was an optional benefit, all States have provided some dental benefits. Clearly, the enhanced Federal match and increased flexibility to tailor benefits have contributed to the success of S-CHIP benefit program. Without both of these incentives the strength of the program would be jeopardized.

Access to dental services and outcomes are better in S-CHIP than in Medicaid. Any further improvements in children's dental health must come from building on the strengths and successes of S-CHIP, and that includes both funding and flexibility. Benefit mandates, or any other attempt to make S-CHIP more like Medicaid will only serve to thwart this progress and could ultimately erode the improvements made so far. NGA will continue to oppose Federal mandates.

States are using S-CHIP to meet children's primary health care needs, including dental health services. Research has shown the S-CHIP enrollees are more likely to have a medical home and more likely to receive preventive dental care. More than half of S-CHIP children have had a dental check-up in the past 6 months and over 80 percent have a usual source of dental care.

States have been working over a number of years to try to improve access to dental care for children. There are a variety of approaches that States have been using, including those that you have heard about today from Michigan. The good news is that dental access is improving for children. Beyond dental, States are also working to meet children's primary health care needs as well as expand affordable health coverage. S-CHIP has seen a success in this area too with over 90 percent of children in the program reporting that they have a usual source of medical care. The overwhelming success of S-CHIP in improving health care coverage and outcomes is why there is unanimous support among governors for a timely reauthorization of the program.

While S-CHIP and Medicaid dental benefits are important, simply having a benefit does not necessarily mean that children receive services. This is particularly true given the shortage of dentists in many areas and more importantly the more acute shortage of pediatric dentists, especially those trained to provide services to children with special health care needs. Therefore, States have taken a more holistic approach to dental care by:

- Promoting Education and Prevention. Much of the disease experienced by children could be prevented with better personal care and water fluoridation. Several States have launched public awareness campaigns to educate parents and children about proper dental care and to build public support for children's oral health policy initiatives.
- Increasing Coverage and Access. Though many low- income children have dental coverage through Medicaid, most receive no preventive dentist visits. Many States are trying to strengthen the safety net by encouraging providers to participate in Medicaid and by including dental benefits in S-CHIP.
- Enhancing the Dental Workforce. Many States are trying to attract dentists to chronically underserved areas, yet the number of dentists graduating from dental school is decreasing nationally. To succeed, States are using loan forgiveness, tax credits, and other incentives and are trying to enhance dentist training to adequately address pediatric needs.
- Improving Financing and Reimbursement. Many providers refuse to participate in Medicaid because of the low rate at which they are reimbursed. Some States have increased provider reimbursements in Medicaid to attract new dentists as well as to bring back dentists who have stopped participating.

Investments in children's health are extremely important, but Governors are also well aware of the need to look more holistically at making investments in children's futures. This is especially true in the area of early childhood development.

Motivated by compelling child development research, impressive cost-benefit evidence, and the persistent achievement gap plaguing our Nation's education system, governors are pursuing pre-kindergarten expansion, full-day kindergarten, child care quality improvement and expansion, infant-toddler initiatives, and other strategies to invest in children's learning and development from birth into the early elementary years. For example:

• New York Governor Elliot Spitzer is calling for full funding of the State's $645 million Universal Pre-K program and for full-day kindergarten planning grants for high-need districts.

• Nevada Governor Jim Gibbons has committed $50 million to support full day kindergarten pilot programs in at-risk schools

• Arizona's recent ballot initiative will direct $188 million in new funds for early childhood development and health programs, in addition to a $200 million increase for voluntary full-day kindergarten programs championed by Governor Janet Napolitano

• Minnesota Governor Tim Pawlenty has proposed $4000 per child for high quality early learning programs for at-risk 4 year olds.

STATE HEALTH CARE REFORM

The State of Hawaii enacted universal health care access in 1974. From that point until 2003, neither the Federal Government nor States made very much process in covering the uninsured. In 2003, the State of Maine enacted a comprehensive proposal with the goal of universal coverage by 2009. This was quickly followed by Vermont and Massachusetts, who enacted plans in 2006 with ambitious goals to cover all of the uninsured. What is of particular note of all three of these plans is that they were bipartisan and subsidized coverage for families up to 300 percent of the Federal poverty level. It is also true that these States had relatively low rates of uninsured prior to enacting reforms. While the three States face significant challenges to implement their plans, the early success in developing a State consensus for reforms has stimulated major reforms in another 20–25 States.

There are about four States that have committed to universal coverage while another ten are developing proposals for universal access to coverage. Several others are focused on universal care for all children and many others are pursing more incremental reforms. There are a number of common elements in these reforms as follows:

State Coverage Extensions. To address the problem of the uninsured, States have enacted plans or are considering proposals to increase coverage and access for many Americans. These initiatives include reforming the individual insurance market, requiring individual or employer participation in health insurance, ensuring that all individual who are eligible for S-CHIP or Medicaid are enrolled and direct subsidies to low-income individuals.

Connectors. A "connector" or "exchange" model offers health coverage through a quasi-governmental authority that negotiates with health insurers to offer a minimum standard of benefits within a certain premium range. The connector pools individuals together to offer affordable, private insurance options. Most "connectors" consolidate the small group and individual markets into the pool. Many States are offering subsidies for low-income individuals to purchase health insurance through the "connector." A choice of plans is provided and portability is a major benefit.

Tax Incentives. Section 125 of the IRS tax code permits tax-free deductions of health insurance premiums from workers' paychecks, saving money for both the employer and employee. Many health reform plans are requiring employers to set up the option for their workers to deduct health insurance premiums tax-free. This option is generally paired with a connector model to ensure minimal administrative burdens for employers.

Employer Mandates. Some States have required employers to either offer insurance to all of their uninsured workers or pay a fee for each uninsured employee. The employer mandate is seen as encouraging employers to continue to offer coverage and helping to fund the coverage expansion in the State. Generally, those States requiring employer contributions are those aimed at achieving universal coverage.

Individual Mandates. Some States are moving toward a requirement on individuals to have health insurance coverage. Through State income tax filings, individuals who can afford coverage and are found not to have insurance will be fined. An individual mandate is being paired with mechanisms to make coverage more affordable for all residents, so individuals have the opportunity to meet the mandate without facing a financial hardship.

Quality Improvements and Measurements. Using coverage expansions and Medicaid redesigns as vehicles, many States have incorporated quality improvement and measurement into their health reform plans to improve efficiency and patient care. Many States are using disease management programs, applying quality measures for doctors and hospitals, and taking steps toward interoperability with electronic data systems.

Benefit Packages. Here, States are negotiating with providers to make a basic benefit package available to current low-income individuals and small businesses. Some of these may be paired with health savings accounts. The benefit package is then offered through the connector.

The question now is how does a mandate for dental health or any other mandate on the Medicaid of S-CHIP benefit package relate to these reform efforts. I would argue that it could well be an obstacle in the following two ways.

- Requires States to spend more money per person in these programs, which redirects funds from eligibility expansions; and
- Limits State efforts to create affordable consolidated insurance markets.

The goal of State actions is universal coverage or universal access. To attain this goal, States use a combination of existing programs, including Medicaid and S-CHIP, and new mechanisms to expand affordable health insurance. If States are required to meet new Federal benefit mandates in either Medicaid or S-CHIP, they will have to spend more money per individual currently covered in these programs. Efforts to enroll eligible uninsured individuals and many planned expansions of these programs will be more expensive for sates. These increased costs will force States to redirect funds that could have been used to fund other affordable health insurance initiatives. Reducing flexibility in these programs is a real obstacle both to maintaining existing coverage as well as coverage expansion.

New mandates on Medicaid and S-CHIP is also a potential obstacle to State efforts to create affordable consolidated insurance markets. Most State coverage efforts include negotiation, with providers to develop basic benefit packages that would be subsidized by States and offered through the connector. Often this would be the same benefit package that is offer by the managed care or other major providers, which is often the same as that provided to State employees. Essentially, the connector consolidates the small group and individual markets into a pool. It then matches providers who are offering benefits with the demand for health care by States via State employees, S-CHIP and Medicaid, as well as small business, State subsidized previously uninsured and other individuals with COBRA or similar needs.

This approach spreads risk, lowers cost, and stabilizes this market. Essentially, mandates that change this benefit package will become an obstacle to the efficiency of these pools. Rather than allow Federal programs to be integrated into the health care system, S-CHIP and Medicaid will continue as separate more expensive programs.

Mr. Chairman, we urge you not to impose any additional mandates on States. Instead Congress should work with States to support current health reform efforts.

MEDICAID VS. OTHER DOMESTIC PRIORITIES

Governors prefer maximum flexibility in administering almost all Federal programs. This allows States not only to tailor their programs to the specific needs of their citizens, but increases the efficiency of programs.

Governors and States now have about 40 years experience with Medicaid. It is the Nation's critical safety net health coverage program for low-income individuals and families. It covers 40 percent of non-elderly Americans living in poverty. It also covers more than 7 million in Medicare of the almost 44 million enrollees, as well as 28 million children or 1 in every 4. Finally, it covers long-term care coverage for 8 million low-income Americans with disabilities and chronic illness. In total, the program now covers 53 million Americans and costs about $317 billion in 2005.

Unfortunately, Medicaid has grown almost 11 percent per year over that last 25 years. It now totals 23 percent of the average State budget, more than States spend on all elementary and secondary education. In States like Tennessee and Missouri it constitutes about 35 percent of their State budgets.

With State revenues growing only about 5–6 percent per year, Medicaid has been funded by cutting virtually all other components of State spending. The stark reality of this in terms of total State spending is as follows:

- Between 1988 and 2005, a 17-year period, Medicaid has grown from 11.5 to 22.9 percent of State budgets. All components of State budgets have been cut to accommodate this increase.

• Elementary and secondary education went from 23.9 percent to 21.8 percent, while higher education went from 12.8 percent to 10.8 percent over the same period. The rest of the cuts came from welfare, economic development, environmental, and infrastructure programs.

Providing health care benefits to all Americans—while critical—is not the only challenge facing State governments. The new world marketplace will challenge our standard of living. The United States used to compete with high wage, high technology countries in the developed world or low wage, low technology countries in underdeveloped countries. Now the United States competes with high technology, low wage emerging nations. Some of these emerging nations are rapidly growing large countries—such as India and China—while others are the smaller Pacific Rim countries, like Taiwan, Korea, and Singapore. But this list also includes many of the nations of Eastern Europe and emerging regions in South America as they join the world marketplace.

Some of these countries compete with the United States in the production of manufacturing goods, from textiles to electronics to automobiles, while others are challenging the United States in Web construction, call centers, software development, and electronic products. Essentially, the changing world market has eliminated most safe havens where a nation's output and jobs are not threatened by increased competition.

The United States' ability to compete in this new knowledge-based highly competitive world economy will depend on its ability to innovate, which in turn depends upon the education and training of our workforce. The economic cost of not being able to innovate will be reflected in the reduction of real wages and real incomes of United States citizens. This may not lead to any crisis in the short term, but reductions in real wages of 1–2 percent a year over the next decade can have a dramatic impact, particularly on low and middle income Americans. Further, reductions in this standard will create tensions among the various groups and societal institutions.

While the United States has witnessed cyclical downturns when real wages have fallen, the trend over the last 200 years has generally been upward. The choice going forward, however, is between reductions in real wages or accelerating the rate of innovation. It is not possible to reestablish trade barriers to protect our current standard of living.

In order to compete in the new emerging global marketplace, we have to dramatically upgrade the education and training of our labor force. To date, our education performance has been less than stellar.

• U.S. 15 year-olds ranked 24 out of 39 countries on the Program for International Student Assessment (PISA) of students' ability to apply mathematical concepts to real world problems.

• In 2004, the U.S. produced 137,000 new engineers while India provided 112,000 and China produced $352,000 adjusted for quality.

Mr. Chairman, at this time States spend about one-third of their revenues on health care and about one-third on education. However, the double digit growth in State health care spending may not be sustained in the future. If the past is a good indication of the future, it would be financed by cuts in education. Future cuts in education, however, will lead to declines in our standard of living.

Health care and education are our two major domestic challenges as we go forward as a nation. It is important to have universal health care or universal access. But it is also important to increase our standard of living, which requires additional spending on education. Governors are attempting to find the appropriate balance between these two challenges.

Mr. PALLONE. Thank you very much.

Ms. Farrell.

STATEMENT OF CHRISTINE FARRELL, R.D.H., M.P.A., MEDICAID POLICY SPECIALIST, MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, MEDICAL SERVICES ADMINISTRATION

Ms. FARRELL. Good morning, Chairman Dingell, Chairman Pallone and Ranking Member Deal and the members of the Subcommittee on Health. My name is Christine Farrell and I am employed with the Michigan Department of Community Health, Medi-

cal Services Administration, the agency that administers the Michigan Medicaid program. For the past 15 years, I have been the dental policy specialist with the responsibility of managing the Medicaid dental benefit. Since 2000 I have served as the contract manager for the Healthy Kids Dental program and this is our partnership with the Delta Dental Plan in Michigan. In addition, I am also a part of the dental team. I am a registered dental hygienist.

Apart from my State role, I also have a national role. I am the national chairperson of the Medicaid/SCHIP Dental Association. We are an association of dental program managers. As an association, we hope to have a more effective voice for the delivery of oral health care to the Medicaid and SCHIP populations since we all share the goal of trying to provide access to oral health services for our beneficiaries. Medicaid/SCHIP Dental Association has worked to promote oral health awareness within our respective programs and we are also working with other oral health advocacy groups, with the Centers for Medicare and Medicaid Services, the National Association of State Medicaid Directors and the National Academy for State Health Policy.

My primary purpose today is to highlight the Michigan Medicaid program and how we are addressing the issue of access to oral health care for Medicaid beneficiaries under the age of 21 through our Healthy Kids Dental program. This is our partnership with Delta Dental Plan of Michigan and it began on May 1, 2000, and continues today. In 1999, the Michigan Legislature appropriated an additional $10.9 million to address the issue of access to oral health services for Medicaid beneficiaries, especially those in rural areas. As a result of dental taskforce recommendations, Michigan chose to use half of these monies to provide infrastructure grants to safety-net providers such as community health centers, local health departments, hospitals and universities. The additional monies went to develop a demonstration project similar to our MIChild dental program, which is our SCHIP program which provides a dental insurance product to enrollees. We set out to contract with a dental insurance carrier to administer the Medicaid dental benefit through a statewide network of dental providers, and Delta Dental Plan answered that call.

The Healthy Kids Dental program was implemented on May 1, 2000, in 22 counties providing access to oral health care services for 50,000 Medicaid beneficiaries. The program was expanded to 37 counties in October 2006 and increased the total beneficiaries to over 100,000. On May 1, 2000, the program expanded to an additional 22 counties, providing access again to another 50,000 beneficiaries. Today it is in 59 of our 83 counties. The majority of these counties are rural. They have dental care health professional shortage areas and have little or no dentist participation in the traditional Medicaid program. Some of these counties have no dentists or one or two.

The Healthy Kids Dental program is designed to mirror an employer-sponsored plan. By partnering with Delta Dental Plan of Michigan, we gained access to their statewide network because approximately 95 percent of the dentists in Michigan participate with Delta Dental whereas less than 20 percent of the practicing dentists are Medicaid providers. By using this network, we provide an

immediate benefit to our Medicaid beneficiaries. We offer them greater access to dentists and the ability to develop a dental home. Another advantage is that they are mainstreamed into the entire population of Delta subscribers and they do not have the stigma of public assistance, and as long as a dentist participates with Delta Dental, they can't refuse to treat Medicaid beneficiaries.

While Delta administers the Medicaid dental benefit, the advantage to their network dental providers is that Delta administers the benefit according to their policies and procedures. Providers submit claims directly to Delta and receive reimbursement from Delta. Initially they were reimbursed at the Delta premier rate, which may be commonly referred to as their usual customary charge. In January 2006, due to budget considerations, Delta Dental and the Medicaid program initiated a reimbursement change to a fixed fee schedule. While this fixed fee schedule is less than their premier rate, it is still higher than our standard Medicaid rate. We were initially concerned that this decrease in reimbursement would impact the network of participating providers and decrease access. This fear was unfounded. We have monitored the provider network and we have retained over 86 percent of the participating dental providers. We attribute this success to the fact that Delta Dental has a strong relationship with their dental network and is a highly respected company by the Michigan Dental Association and its members.

We have contracted with a University of Michigan researcher, Dr. Stephen Eklund, to assess the results of the Healthy Kids Dental program and we have just released a study showing that 5 years of operation where it shows that dental visits are 50 percent higher for children enrolled in the Healthy Kids Dental program compared to our traditional Medicaid dental program. Additional results show that travel distance has also been cut in half from the traditional Medicaid beneficiary experience. In addition, many Healthy Kids dental beneficiaries have established a dental home and are developing routine dental recall patterns. The results are impressive and we are very excited about them.

In addition, Delta Dental Plan recently conducted a survey of Healthy Kids Dental participants and the majority of them are also satisfied.

The goal of the Healthy Kids Dental program is to increase access to oral——

Mr. PALLONE. Ms. Farrell, I am going to have to ask you to summarize too.

Ms. FARRELL. Oh, I am sorry.

We think we have demonstrated success and Michigan would welcome additional Federal assistance to assist us in further expanding the Healthy Kids Dental program and we are in challenging economic times and we continue to look at innovative ways to increase our oral health care access.

[The prepared statement of Ms. Farrell follows:]

TESTIMONY OF CHRISTINE FARRELL

Good morning Chairman Dingell, Chairman Pallone, Ranking Member Deal and the members of the Subcommittee on Health.

My name is Christine Farrell and for the past 19 years I have been employed by the Michigan Department of Community Health, Medical Services Administration (the agency that administers the Michigan Medicaid Program). For the past 15 years, I have been the dental policy specialist with the responsibility of managing the Medicaid dental benefit. Since 2000, I have served as the contract manager for the Healthy Kids Dental program; this is our partnership with the Delta Dental Plan of Michigan.

Apart from my State role, for the past 3 years, I have been the national chairperson of the Medicaid/SCHIP Dental Association (MSDA). This association was formed 3 years ago at the National Oral Health Conference by Medicaid and SCHIP dental program managers. As an association, we hope to have a more effective voice for the delivery of oral health care to the Medicaid and SCHIP populations. Our mission is to provide a support system and promote collegiality among State Medicaid and SCHIP programs since we all share the goal of trying to provide access to oral health services for our beneficiaries. Since forming this association, the MSDA has worked to promote oral health awareness and to increase access to oral health services for Medicaid and SCHIP beneficiaries within our respective State programs, with the Centers for Medicare and Medicaid Services (CMS) Chief Dental Officer, with national policy groups such as the National Association of State Medicaid Directors (NASMD), the National Academy for State Health Policy (NASHP), and other oral health advocacy groups. Our Association seeks the opportunity to provide State and national leadership in the development of Medicaid/SCHIP oral health policy, encourage innovation and collaboration among State Medicaid programs, and to promote the integration of oral health and primary care in Medicaid/SCHIP programs.

My primary purpose today is to highlight the Michigan Medicaid Program and how we are addressing the issue of access to oral health care for Medicaid beneficiaries under the age of 21 through our Healthy Kids Dental program. The Healthy Kids Dental program is our partnership with the Delta Dental Plan of Michigan. This partnership began on May 1, 2000 and continues today.

In 1999, the Michigan legislature appropriated an additional $10.9 million dollars to address the issue of access to oral health services for Medicaid beneficiaries, especially those in rural areas. As the result of Dental Task Force recommendations, Michigan chose to use half of the monies to provide infrastructure grants to safety-net providers, such as community health centers, local health departments, hospitals and universities. The additional monies went to develop a demonstration project similar to the MIChild dental program (Michigan's SCHIP program) which provides a dental insurance product to enrollees. We (Medicaid) sent out a proposed bulletin announcing the intent to contract with a dental insurance carrier to administer the Medicaid dental benefit through a statewide network of dental providers.

The Healthy Kids Dental program was implemented on May 1, 2000, in 22 counties providing access to oral health care services for 50,000 Medicaid beneficiaries under the age of 21. The program was expanded to 37 counties in October, 2006, and increased the total beneficiaries enrolled to over 100,000 enrollees. On May 1, 2006, the program expanded to an additional 22 counties providing access to another 50,000 beneficiaries. Today, it is in 59 of the 83 Michigan counties providing access to oral health care services for over 200,000 beneficiaries. The majority of these counties are rural, are Dental Care Health Professional Shortage Areas, and have little or no dentist participation in the traditional Medicaid Program.

The Healthy Kids Dental program is designed to mirror an employer-sponsored plan. By partnering with Delta Dental Plan of Michigan, we have gained access to their statewide network. Approximately 95% of the practicing dentists in Michigan participate with Delta Dental whereas, less than 20% percent of the practicing dentists are Medicaid providers. By using this network, we provide an immediate benefit to our Medicaid beneficiaries by offering them greater access to dentists and the ability to develop a dental home. Another advantage for the beneficiaries is that they are mainstreamed into the entire population of Delta subscribers by receiving a Delta Dental card; they do not have the stigma of public assistance. As long as the dentist participates with Delta Dental, they cannot refuse to treat Medicaid beneficiaries unless the office is closed to all new patients.

While Delta administers the Medicaid dental benefit, the advantage to their network dental providers is that Delta administers the benefit according to their policies and procedures, providers submit claims directly to Delta and receive reimbursement from Delta. Initially, the dentists were reimbursed at the Delta Premier rate (may be commonly referred to as their Usual & Customary Charge). In January 2006, due to budget considerations, Delta Dental and the Medicaid Program, initiated a reimbursement change from the Premier rate to a fixed fee schedule. While this fee schedule is less than the Premier rate, the rate is still higher than the

standard Medicaid fee schedule. We (both Medicaid and Delta Dental) were initially concerned that this decrease in reimbursement would impact the network of participating providers and decrease access. This fear was unfounded. We have monitored the provider network and have retained over 86% of the participating dental providers. We attribute this success to the fact that Delta Dental has a strong relationship with their dental network and is a highly-respected company by the Michigan Dental Association and its members.

A University of Michigan researcher, Dr. Stephen A. Eklund, was contracted to assess the results of the Healthy Kids Dental program. A study using data from the first 5 years of operation has just been completed and the results are impressive. Results show that dental visits are 50 percent higher for children enrolled in the Healthy Kids Dental program compared to children enrolled in the traditional Medicaid dental program. Additional results show that the travel distance for beneficiaries has been cut in half from traditional Medicaid experience. The median distance traveled is 7.6 miles for Healthy Kids Dental beneficiaries, whereas beneficiaries in the traditional Medicaid Program normally travel twice that distance. In addition, many Healthy Kids Dental beneficiaries have established a dental home and are developing routine dental recall patterns. The results of the study are impressive and we (both Medicaid and Delta Dental) are excited about them. It demonstrates that the partnership with Delta Dental is working.

In addition, Delta Dental Plan recently conducted a survey of Healthy Kids Dental participants. Of the respondents, nearly 99 percent are satisfied with the program and 92 percent indicated that their child's health has improved due to the Healthy Kids Dental program.

In 2004, the American Dental Association designated the Healthy Kids Dental program as one of five national models for improving access to oral health services for Medicaid beneficiaries.

The goal of the Healthy Kids Dental program is to increase access to oral health services for Medicaid beneficiaries and to eliminate barriers. We believe that the program has accomplished this goal through our partnership with Delta Dental Plan of Michigan. We have addressed the three most common complaints typically reported about the Medicaid Program: low reimbursement rates, administrative burden and beneficiary no-show rates. We have also improved the health of the beneficiaries by crafting a new model that is working in Michigan.

While this program has demonstrated success, Michigan would welcome additional Federal assistance to assist us in further expanding the Healthy Kids Dental program statewide. We are in challenging economic times in Michigan and we continue to look at innovative ways to improve access to oral health care. Additional Federal support would assist Michigan, and other States, in crafting solutions to improve and expand access to this critical benefit for children.

Mr. PALLONE. Thank you. I would also say you can submit your full statement for the record too. We are just trying to get you to summarize your comments within the minutes or so.

Next is Dr. Mosca.

STATEMENT OF NICHOLAS G. MOSCA, D.D.S., CLINICAL PROFESSOR OF PEDIATRIC AND PUBLIC HEALTH DENTISTRY, UNIVERSITY OF MISSISSIPPI SCHOOL OF DENTISTRY

Dr. MOSCA. Good morning, Mr. Chairman and members of the committee. My name is Dr. Nicholas Mosca. I am clinical professor of pediatric and public health dentistry at the University of Mississippi School of Dentistry and also serve as State dental director for Mississippi. It is an honor to testify on behalf of two organizations, the American Dental Education Association, which represents over 21,000 members at more than 120 academic dental institutions including 56 schools of dentistry in 34 States, the District of Columbia and Puerto Rico, and the American Association for Dental Research, which represents 5,000 individual and 100 institution members.

Each year about 4,500 pre-doctoral dental students graduate from dental school. Fourteen thousand dental hygienist students

graduate. Eight thousand dental assistants and 800 dental laboratory technologists graduate. Many of these students are trained in clinical environments where dental care is provided to underserved low-income populations including individuals covered by Medicaid and the State Children's Health Insurance Program.

Let me share with you, as did New Mexico, Utah and California, a snapshot of Mississippi. During the 2004–05 school year, 7 in 10 third-grade children experienced tooth decay. Two in five had untreated dental disease, and 1 in 10 had urgent need for dental care, which means that over 3,800 children had urgent need for care. Almost twice as many African-American children were in need of urgent care because of pain or infection.

On March 23, at a Head Start program in Clarksdale, Mississippi, the birthplace of the blues, I saw a 4-year-old child with an acute dental abscess. We have all been talking about the untimely death of Diamonte Driver but let me also share another example of an access issue. A week ago in USA Today, it was reported that a routine dental visit revealed a cancerous tumor in the mouth of North Carolina football coach Butch Davis. Coach Davis is now undergoing chemotherapy for non-Hodgkin's lymphoma. His access to oral health care in combination with dental insurance played a critical role in saving his life. These two examples reveal opposing sites of access to dental care in America. One individual lacked consistent care while the other was well insured and had timely care.

Once upon a time, access to dental care meant the removal of bad teeth and the fabrication of dentures. Dental care is no longer akin to making hearing aids or eyeglasses. In other words, we must work to prevent most infection and pain from occurring in the first place. Healthy adult mouths have 32 teeth which are supplied by blood vessels, just like our fingers. How can we afford to allow our children's fingers to become infected? How many fingers could you afford to lose? The real tragedy is that we know how to prevent most tooth decay in most populations. We only need to act on our knowledge.

Prevention of disease such as by public water fluoridation or school-based dental sealant programs is essential to contain the higher costs associated with care. Children who receive early preventive care are more likely to continue using prevention services and those who wait to visit a dentist are more likely to have a costly health problem or require an emergency room visit.

Our U.S. academic dental institutions act to mitigate these emergency room visits by serving as safety-net providers to provide comprehensive care at reduced costs and we serve racially and ethnically diverse populations including low-income, elderly, migrant individuals, home-bound individual, mentally, medically and physical disabled individuals. As providers of services to underserved populations, academic dental institutions may also enhance Government initiatives to expand access to prevention and dental care. Schools can work with State oral health programs to support school-based dental programs, sealant programs, and schools can conduct research to evaluate the dental workforce capacity needed to adequately serve those in Medicaid, Ryan White HIV dental clinics and other public assistance programs.

Here are some fairly straightforward ways in which Congress can immediately act to enhance access to vital preventive and restorative services. We urge Congress to adopt the following recommendations for the reauthorization of the SCHIP program, establish a Federal guarantee for dental coverage in SCHIP, develop a dental wraparound benefit in SCHIP, facilitate ongoing outreach efforts to enroll all eligible children in SCHIP and Medicaid, and ensure reliable data reporting on dental care in SCHIP in Medicaid. We further urge Congress to ensure that there is adequate funding of the Federal programs that increase access to oral health care and improve oral health infrastructure and dental research and bolster the oral health care workforce for the Nation. You already had many of these programs named and so I just want to reiterate that we know how to prevent most disease in most populations. We only have to act on this knowledge.

Thank you, and I am happy to field any questions that you may have.

[The prepared statement of Dr. Mosca follows:]

STATEMENT OF NICHOLAS G. MOSCA, D.D.S.

Mr. Chairman and members of the committee, I am Dr. Nick Mosca, Clinical Professor of Pediatric and Public Health Dentistry at the University of Mississippi School of Dentistry and Dental Director for the State of Mississippi. I am a member of the American Dental Education Association (ADEA) and the American Association for Dental Research (AADR). This morning I am testifying on behalf of both organizations.

The ADEA represents over 120 academic dental institutions as well as all of the educators, researchers, residents and students training at these institutions and AADR represents over 5,000 individual members and 100 institutional members. The joint mission of ADEA and AADR is to enhance the quality and scope of oral health, advance research and increase knowledge for the improvement of oral health, and increase opportunities for scientific innovation. Academic dental institutions play an essential role in conducting research and educating and training the future oral health workforce. These institutions provide dental care to underserved low-income populations, including individuals covered by Medicaid and the State Children's Health Insurance Program.

I thank the committee for this opportunity to testify about access to oral health care, the role academic dentistry plays in providing care for underserved populations and the role we play in educating a competent and diverse oral health care workforce for the Nation.

Preventive Care is Essential to Eradicate Oral Health Disparities and Contain Costs

Americans spend millions of dollars annually in treatment of dental caries (cavities) and tooth restoration. Despite tremendous improvements in the Nation's oral health over the past decades, the benefits have not been equally shared by millions of low-income and underserved Americans.

As the Surgeon General's report on oral health in America told us 7 years ago, there are ″profound and consequential oral health disparities within the population,″ particularly among racial and ethnic minorities, rural populations, individuals with disabilities, the homeless, immigrants, migrant workers, the very young, and the frail elderly.″ At the time of publication of the Surgeon General's Report there were 108 million Americans lacking dental insurance, of which 23 million were children.

Children in households below 200 percent of poverty have three times the tooth decay of children from affluent homes. Their disease is more advanced and is less likely to be treated. Eighty percent of untreated dental caries (tooth decay) is isolated in roughly 25 percent of children. The majority of these children are from low-income and other vulnerable groups—the same groups that rely upon public health programs for their care. Most adults, particularly as they age show signs of periodontal or gingival disease. Fourteen percent of people age 45 to 54 have severe periodontal disease and that number grows to almost a quarter (23 percent) for people

age 65 to 74. Tragically one-third of adults (30 percent) are completely toothless (edentulous).

Access to oral health care can be a matter of life and death. Those of us who read the Washington Post were reminded of that recently with the untimely death of Deamonte Driver, a 12-year-old boy with an abscessed tooth, part of an uninsured and sometimes homeless family whose Medicaid coverage had lapsed. Deamonte's tooth infection spread to his brain. After two brain surgeries and six weeks in the hospital (and tens of thousands of dollars in medical expenses), he died. A week ago USA Today reported that a routine dental visit revealed a cancerous tumor in the mouth of North Carolina football coach Butch Davis. Coach Davis is now undergoing chemotherapy for non-Hodgkin's lymphoma. His access to oral health care, in combination with dental insurance played a critical role in saving his life.

America's most prevalent infectious disease is dental decay (caries) for all ages. It is five times more common than asthma and seven times more common than hay fever in children. Early childhood caries is dental decay found in children less than 5 years of age. It is estimated that 2 percent of infants 12–23 months of age have at least 1 tooth with questionable decay whereas 19 percent of children 24–60 months of age have early childhood caries in the United States. [1]

Preventative care is essential to contain costs associated with oral health care treatment and delivery. Children who have early preventive dental care are more likely to continue using preventive services. Those who wait to visit a dentist are more likely to visit for a costly oral health problem or emergency. The average cost for a dental visit before age one was $262. This doubled to $546 when a child's first visit wasn't until ages 4 to 5 [2]

Dental caries is a chronic, infectious disease process that occurs when a relatively high proportion of bacteria within dental plaque begin to damage tooth structure. If caries can be diagnosed before irreversible loss of tooth structure occurs, it can be reversed using a variety of approaches that "remineralize" the tooth. In addition to improved diagnostics, researchers are working to develop a vaccine to prevent tooth decay while others use new methods to specifically target and kill the decay-causing bacteria.

Academic Dental Institutions and Access to Care

U.S. academic dental institutions (dental schools, allied dental programs and postdoctoral/advanced dental education programs) are safety net providers increasing access to care. These institutions are dental homes for a broad array of racially and ethnically diverse patients including low-income non-elderly and elderly individuals; migrant individuals; homebound individuals; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and SCHIP children and uninsured individuals.

All U.S. dental schools operate dental clinics and most have affiliated satellite clinics where preventative and comprehensive oral health care is provided as part of the educational mission. All dental residency training programs provide care to patients through dental school clinics or hospital-based clinics. Additionally, all dental hygiene programs operate on-campus dental clinics where classic preventive oral health care (cleaning, radiographs, fluoride, sealants, nutritional and oral health instruction) can be provided 4–5 days per week under the supervision of a dentist. All care provided is supervised by licensed dentists as is required by State practice acts. All dental hygiene programs have established relationships with practicing dentists in the community for referral of patients. Millions of dollars of uncompensated care are provided by academic dental institutions each year.

As major providers of services to underserved populations, academic dental institutions also play a major role in enhancing private sector initiatives that support expanded access to dental care. They support school-based sealant programs that reduce the incidence of tooth decay in children; and they evaluate the dental workforce capacity needed to adequately serve those in Medicaid, Ryan White HIV/AID clinics and other public assistance programs.

Educating the Nation's Oral Health Care Workforce

Oral health care is important for all Americans including those living in inner cities and in rural underserved areas. There are presently more than 3,400 designated dental health profession shortage areas, in which 45.3 million people live. It is

1 "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs," Matthew F. Savage, DDS, MS, Jessica Y. Lee, DDS, MPH, PhD, Jonathan B. Kotch, MD, MPH, and William F. Vann, Jr., DMD, PhD, Pediatrics Vol. 114, No. 4, October 2004.

2 Ibid

doubtful that many of these areas can financially support a dentist or attract a dentist by virtue of their infrastructure or location. But the issue remains. There are unserved and underserved communities and populations, as well as a growing desire in society to have equitable access to health care and dental care for all. The challenge to dentistry is not only to expand the capacity of the dental workforce; it must also improve its distribution and access to oral health care. In order to achieve these objectives it is the mission of academic dental institutions to educate and train the U.S. dental health care workforce.

Predoctoral Dental Education. Upon successfully completing dental school and passing a State licensure exam graduates may enter private practice as general dentists. Graduate also have the option to pursue advanced and specialty training.

At the present time about 4,500 predoctoral dental students graduate annually after 4 years of dental school. The high water mark for dental student enrollment occurred in the late 1970's with 6,300 students. Enrollment increased during the 1960's and 1970's due to surges in both the baby boomers coming of college age and the percent of college age adults enrolling in college. Also, there was broad support for expanding the number of health care providers during that time which led to Federal student loan and scholarship programs, as well as Federal construction and capitation grants to schools to support enrollment increases. Then during the late 1970's and through the 1980's there were declines in enrollment which can be attributed to a strongly voiced perception of an oversupply of dentists, periods of economic inflation and stagnation, and termination of Federal support for further expansion in the numbers of health care providers. During the mid–1990's, applicants to dental school increased as dentistry was once again perceived to be a challenging and financially rewarding profession. However, enrollment increased only slightly. It should be noted that there is limited capacity within the current dental education infrastructure to accommodate much of an enrollment increase. And until recently, there was not support or need to do so nationally.

At the present time there are 56 U.S. dental schools in 34 States, the District of Columbia and Puerto Rico. Growing demand for dental care in certain areas of the country has precipitated the opening of six new dental schools. In 2003 the Arizona School of Health Sciences, the University of Nevada Las Vegas in 2002, and the Nova Southeastern University in Florida in 1997. In near future East Carolina University in Greenville, North Carolina plans to open a dental school with a focus on rural dentistry. The school plans to operate 10 student dental clinics in underserved communities throughout the State enrolling 50 students per class. Midwestern University in Glendale, Arizona will open a dental school in August 2008 with an enrollment of 100 students per class. The dental school is part of Midwestern's expansion plan to address the State of Arizona's health care workforce shortages. Western University of Health Sciences in Pomona, California plans to open a dental school in the next few years. The University is in the preliminary phase of the accreditation process.

Prior to these openings, significant growth took place from 1960–1978 with the number of dental schools increasing from 47 to 60. This increase of 13 was during a time of Federal construction grants and a widely perceived need to expand the number of all health care professionals, including dentists. Between 1986–2001, seven dental schools closed, all private or private/State-related dental schools.

Dental Residency Training. Approximately 2,800 new graduates and other dentists who have been in practice choose to specialize or advance their training in general dentistry by enrolling in dental residency training programs. There are nine recognized dental specialties: oral surgery, oral radiology, oral pathology, orthodontics, endodontics, periodontics, pediatric dentistry, dental public health as well as two programs in general dentistry, general practice residency and advanced education in general dentistry. Dental residency training programs last from a minimum of 14 months for Dental Public Health up to maximum of 54 months for oral surgery. Dental residency programs increase access to oral health care for a broad array of patients. Dentists may not practice a dental specialty without having successfully completed the required training.

In 1995, the Institute of Medicine called for the creation of a number of graduate dental education residency positions sufficient to accommodate all graduates by 2005. In 1999, the Journal of Dental Education published a series of articles in a special issue that set forth a focused and compelling rationale for a mandatory, postgraduate year of dental residency education (PGY–1). The most recent call for a PGY–1 was in December 2006 at the ADEA Summit on Advanced Dental Education. Delaware has long required a residency before dentist could begin practice in the State. Beginning this year the State of New York requires a PGY–1 for initial licensure.

Allied Dental Education There are about 300 dental hygiene programs in all 50 States and the District of Columbia. Most dental hygiene programs grant an associate degree, others offer a certificate, a bachelor's degree, or a master's degree. Dental hygienists rank among the fastest growing occupations. Each State has its own specific regulations regarding dental hygiene responsibilities thus services provided varies from State to State. Nearly 13,900 dental hygienists graduate annually.

There are 272 dental assisting programs located in 47 States and Puerto Rico. Dental assistants enhance the capacity of a dental office to treat patients by assisting dentists with a variety of treatment procedures. About 8,000 dental assistants graduate each year.

Eight hundred students graduate annually from the 20 dental laboratory technology programs located in 16 States. These individuals create replacements for natural teeth and corrective devices; fabricate dentures, bridges, crowns and orthodontic appliances and work with a variety of materials such as waxes, plastics, precious and non-precious alloys, porcelains and others to fabricate dental restorations and tooth replacements.

MEDICAID AND SCHIP

More than 9 million children lack medical insurance and 23 million children lack dental insurance. Medicaid plays a critical role in children's access to dental services. In fact, Medicaid pays for 25 percent of all dental expenses for children under 6 years of age. Also, Medicaid covered 66 percent of the dental expenses incurred for all people with public insurance.

All 25 million children in Medicaid under age 21 are eligible for needed dental care through the Early Periodic Screening, Diagnosis and Treatment program (EPSDT). Dental services were among the first three preventive health care services included in EPSDT. Although all children enrolled in Medicaid qualify for EPSDT services, less than one in four children on Medicaid receive them.

State Medicaid programs are required to ensure that dental services are available and accessible and to provide services if a problem is identified that requires treatment. States must also inform Medicaid-eligible persons about the availability of EPSDT services and assist them in accessing and utilizing these services. Services include regular screenings and dental referrals for every child at regular intervals meeting reasonable standards of dental practice established by States in consultation with the dental profession. States must provide, at a minimum, services that relieve pain and infection, restore teeth, and maintain dental health.

The State Children's Health Insurance Program (SCHIP) plays a critical role in providing access to dental care for covered children. Although States have the option to include dental coverage (presently all States have some level of dental benefits) the fact that they do so is a significant factor in a parent's decision to enroll their children in SCHIP.

As Congress deliberates the reauthorization of the SCHIP, ADEA/AADR urges Congress to immediately enact legislation that would enhance SCHIP insurance coverage and enhance access to dental care. We recommend that Congress enact following recommendations to improve the system of care: (1) Establish a Federal guarantee for dental coverage in SCHIP; (2) Develop a dental wrap-around benefit in SCHIP; (3) Facilitate ongoing outreach efforts to enroll all eligible children in SCHIP and Medicaid; and (4) Ensure reliable data reporting on dental care in SCHIP and Medicaid.

Dental care for adults under Medicaid is optional. As a result, many States often reduce or eliminate funding for adult dental programs during difficult economic times

Today, most States have caps or limits on spending for adult oral health and dental services. Forty-one States offer only emergency care. As States begin to recover from the recent economic recession, some are reinstating limited oral health and dental services for adults; however, only a relatively few States provide comprehensive adult services. For many Medicaid-eligible adults this is the only insurance coverage they have for oral health and dental care.

FEDERAL PROGRAMS THAT HELP TO ADDRESS ORAL HEALTH WORKFORCE ISSUES

The Dental Health Improvement Act, a Federal grant program for States, awarded the first 18 grants to States last October to help develop innovative dental workforce programs. The first grants are being used for a variety of initiatives including: increasing hours of operation at clinics caring for underserved populations, recruiting and retaining dentists to work in these clinics, prevention programs including water fluoridation, dental sealants, nutritional counseling, and augmenting the State dental offices to coordinate oral health and access issues.

The Title VII General and Pediatric Dentistry Programs are essential to building the primary care dental workforce are effective in increasing access to care for vulnerable populations including patients with developmental disabilities, children and geriatric patients. These primary care dental residency programs generally include outpatient and inpatient care and afford residents with an excellent opportunity to learn and practice all phases of dentistry including trauma and emergency care, comprehensive ambulatory dental care for adults and children under the direction of experienced and accomplished practitioners.

The Centers for Disease Control and Prevention Oral Health Program expands the coverage of effective prevention programs by building basic capacity of State oral health programs to accurately assess the needs in their State, organize and evaluate prevention programs, develop coalitions, address oral health in State health plans, and effect allocation of resources to the programs. CDC provides technical assistance to States that is essential to help oral health programs build capacity.

Congress designated dental care as a "core medical service" when it reauthorized the Ryan White Modernization and Treatment Act in 2006. Seventy-five percent of the funding for titles I and II must be devoted to core medical services. This should result in many more afflicted patients receiving the dental care they need. The Dental Reimbursement Program provides access to quality dental care to people living with HIV/AIDS while simultaneously providing educational and training opportunities to dental residents, dental students, and dental hygiene students who deliver the care. The Dental Reimbursement Program is a cost-effective Federal/institutional partnership that provides partial reimbursement to academic dental institutions for costs incurred in providing dental care to people living with HIV/AIDS. The Community-Based Dental Partnership Program fosters partnerships between dental schools and communities lacking academic dental institutions to ensure access to dental care for HIV/AIDS patients living in those areas.

The under representation of minorities poses a challenge to the U.S. health care workforce, including dentistry, especially as immigration trends contribute to increased numbers of minorities in the population. Title VII Diversity and Student Aid programs play a critical role in helping to diversify the health professions student body and thereby the health care workforce. Of paramount importance are the Health Careers Opportunity Program, the Centers of Excellence and the Scholarships for Disadvantaged Students. These programs are key drivers in recruiting and retaining students in the health professions. For the last few years these grant programs have not enjoyed an adequate level of support to sustain the progress that is necessary to meet the challenges of an increasingly diverse U.S. population.

ACADEMIC DENTAL INSTITUTIONS RECOMMENDATIONS

Oral disease affects individuals, families, the community and society. Poor oral health can lead to pain and infection, missed work or school and disruptions of vital functions such as speech and eating, and other productive activities. Oral disease not only poses a risk to general health it can complicate other existing medical conditions.

While dental care demands are higher than many other health care demands, many people in the U.S. do not receive basic preventive dental services and treatment. Most oral diseases are preventable if detected and treated promptly. Yet millions of Americans face unacceptable conditions in oral health living daily with pain and disability without treatment. The major reason for not obtaining dental services is financial. Since few oral health problems in their early stages are life-threatening, people often delay treatment for long periods of time. Often, it is hospital emergency rooms to which they turn once they can no longer stand the pain or their condition has worsened to the point where they can no longer postpone treatment.

ADEA/AADR urges Congress to adopt our SCHIP recommendations as set forth in this testimony that will greatly enhance access to vital preventive and restorative oral health care services: (1) Establish a Federal guarantee for dental coverage in SCHIP; (2) Develop a dental wrap-around benefit in SCHIP; (3) Facilitate ongoing outreach efforts to enroll all eligible children in SCHIP and Medicaid; and (4) Ensure reliable data reporting on dental care in SCHIP and Medicaid.

Furthermore, we urge Congress to ensure adequate funding of the Federal programs outlined above, namely Medicaid and SCHIP, the Dental Health Improvement Act, Title VII General and Pediatric Dentistry Programs, the Centers for Disease Control and Prevention Oral Health Program, the Ryan White Modernization and Treatment Act and the title VII diversity and student aid programs which include the Health Careers Opportunity Program, the Centers of Excellence and the Scholarships for Disadvantaged Students.

Mr. PALLONE. Thank you, Dr. Mosca.

Dr. Corbin.

STATEMENT OF STEPHEN B. CORBIN, D.D.S., M.P.H., SENIOR VICE PRESIDENT OF CONSTITUENT SERVICES AND SUPPORT, SPECIAL OLYMPICS INTERNATIONAL

Dr. CORBIN. Good morning, and thank you again for having us here to share information on a very important topic, and a lot of verbal and written information will come across these tables and it will go into the record, but I think it is important that we get back to what this is all about. If you look to your left or your right and you see on your screen, you will see examples of very serious early dental infections in young children, as young as 3 or 4 all the way up to 6 or 7. So at the end of the day Diamonte Driver is a statistic, a dead child who should still be alive, and again, he is not the exception. There are many children out there that have these problems.

There is one barrier we need to get over right in the beginning and it is not micromanaging the reimbursement levels or anything like that. It is a conceptual barrier. A decade ago, C. Everett Koop said if you don't have oral health, you are not healthy. Medical and dental science over the past decade has advanced and shown that Dr. Koop was indeed right and we know that to be the case today. At the same time, 15 years ago, I heard for the first time in a State legislature this quote, or this is a paraphrase that is close to a quote: sure, it would be nice to save the dental program but let us face it, no one really dies from a toothache. This was not a single legislature. This is going on over and over, over the past 15 years, and it really strikes the contrast, the balance about is dentistry about filling holes in teeth that happen and can happen now or a year from now or is it about ongoing health care and well-being for children, adolescents and adults, and I think you will agree with me, it is the latter. There are many points along the way where we could have intervened in the death march that took Diamonte Driver to a way-too-premature end to his life.

I am a board-certified public health dentist. It is a rare breed. You won't find another one probably within—oh, other than Burt. Are you certified? I don't know. I work with Special Olympics International. We have a global health program now. We have a global health program because the people who work in health and not sports were not getting the job done for our population. We do 130,000 free health screenings a year. We have a program called Special Olympics Special Smiles and based on 5,500 screenings of our athletes, half of whom are under the age of 21, consider these statistics. Twelve percent report pain in their mouths at the time we are doing the screening. More than a third have obvious signs of gingival infection. That means when you look at it, you can see it. You don't need a microscope. A fourth have obvious dental decay. No X-rays, no taking a sharp pick and sticking it into the tooth. You look and you see it. A quarter are missing teeth. Missing teeth, that is a reflection of a lack of continuous comprehensive and early preventive and treatment care. Most of them, at least half, have dental plaque that leads to oral infections of the soft and hard tissues. Too many families say that they just don't have ac-

cess to regular dental care for their children. One of ten of their children is in need of urgent care.

We have also done some research into the issue of training health professionals, physicians and dentists. We did a national survey of dental and medical schools and post-graduate programs. The vast majority of dental and medical students say they don't feel prepared to deal with the population of intellectual disabilities when they graduate, and half or more of the deans tell us their students are not prepared to treat this population when they graduate, so that obviously begs the question of what needs to be done in terms of professional education.

One of my most recent disappointments, a year and a half ago, we started a Web-based provider directory where providers could self-identify as willing to speak to people with intellectual disabilities or their parents about care, not a guarantee of treatment, not a guarantee of price, just the willingness to speak about care. There are well over a million health professionals in the United States and over 150,000 dentists in the United States. We contacted the organizations in writing. We followed up by telephone calls. We got a few articles in some magazines and journals but I got to say, a year and a half later it is one of my greatest disappointments. Less than 1,000 people have signed up for this multidisciplinary provider Web site out of well over a million providers, and I think at last count there was about 258 dentists that had registered for this. This is certainly very, very disappointing for a family who has a child with an intellectual disability.

Now, if I could show you one more picture here.

[Slide]

This is Mr. James Pearce. He is from Kentucky. He showed up at a clinic in Lexington, Kentucky, looking like what he looks like on the left. That reflects obvious dental disease, and even up on the screen you don't have to be a specialist to see that there are some serious problems there, infected teeth, missing teeth, grossly infected soft tissues. James is ill. He has swelling around the eye there. James in that picture is barely alive to a lot of people, and James in that picture on the left is somebody who is not going to be out in the front working in a business serving customers but thanks to Dr. Henry Hood, a developmental medicine dentist who took James on, they were able to do a very good job of dealing with James' dental needs. As I said, he has a moderate intellectual disability. James is doing very well now. James can stand out in front. James is somebody who you could say, I could be a friend to James. So I think you can see that what happened on the left didn't happen overnight. That started clearly in his youth, went through his adolescence, young adulthood and that is what we get. And this is one of the problems with this population.

Mr. PALLONE. I am going to have to ask you to wrap up again because you are over a minute too.

Dr. CORBIN. Then I will wrap up and say I endorse many of the recommendations that I have heard here about how we can maintain an enhanced coverage for this population.

One thing I would really like you to look into is tell me why people with ID are not considered by the Federal Government to be a medically underserved population and tell me why when a person

with intellectual disability in the fifth-grade intellectual level gets kicked out of the EPSDT program when that person turns 21. It makes absolutely no sense.

[The prepared statement of Dr. Corbin follows:]

TESTIMONY OF STEPHEN CORBIN

"Sure, it would be nice to save the dental program, but, let's face it: No one really dies from a toothache." I start out my testimony today paraphrasing a common misperception that State legislatures have debated over the past three decades about Medicaid dental programs. As you will see, this statement is both prescient and false and underlies much of what is wrong with public dental programs in the country today.

Good morning. I am Dr. Stephen Corbin, senior vice president for Constituent Services and Support at Special Olympics International. I am honored to be invited to participate in this important hearing on access to dental care. This is a matter to which I have dedicated years of study and service and, I am loathe to admit, have not seen the breakthrough progress that is so badly needed.

I understand that the recent tragic death of 12-year-old Deamonte Driver from the complications of untreated dental decay has heightened awareness all the way up to the halls of Congress that action is essential so that such a tragedy never happens again. As with so many things in society that are unjust and preventable, it often takes a sudden tragedy to garner attention on long-standing tragedies. It appears that this may be such a case. If we can use the moment constructively, we can honor the memory of a young child who became the victim of a failed system. He and his family were ill-served. They did not have any control over the office policies of any healthcare providers or payment policies of a public financing system.

What we all need to realize is that Deamonte Driver not only died as a result of the passive complicity of a failed system, but he suffered for months, possibly unaccounted years, from the chronic pain of infections that invaded his teeth and eventually spread to supporting structures, his blood stream and his brain. Was this some exotic new infectious invader unknown to medical science? Was this a unique case, such as had never been seen before? Was this a clinical condition for which there is no known treatment? Sad to say, the answers to these questions are "no, no and no!"

If you were to track back to the cause of death in this instance, one could say that the immediate cause of death was heart failure, precipitated after an infection of the brain, arising out of a blood-borne infection, that moved from an infected pulp of a tooth, that had been preceded by a deep carious lesion of the dentin of the tooth, that was preceded by an extensive carious lesion of the enamel, that was preceded by a minimally invasive carious lesion of the enamel, that was preceded by a barely detectable lesion of the enamel, that was preceded by an insensitive, incomplete and under funded medical system that never gave Deamonte Driver the chance he needed. The chance that he needed to recover and survive.

The bottom line is there were numerous points along the way where this death march could have been halted; where the infection could have been prevented or intercepted early, or if late, still could have been tackled. And, a young life could have been saved. Why did Deamonte Driver have to die from probably the most common childhood affliction, from a disease that we have known how to prevent and treat for more than 100 years? The answer to this question is complex, and I hope that, by the end of this hearing, we will know enough to be able to move forward with specific actions to change this situation permanently.

While I am a dentist and a Board Certified Public Health Dentist (a rare breed indeed), I currently lead a global multi-disciplinary health program for persons with intellectual disabilities, some 2.25 million Special Olympics athletes worldwide, more than half under the age of 21. Special Olympics has stepped forward as a global leader to address the burden of unmet health needs for the more than 170 million persons around the world, including 6 million in the United States, with intellectual disabilities. Not because we were inclined to, as a sports organization, but because we really had no choice. Where those who should have taken care of this have failed to do so, Special Olympics stepped up. If you are not healthy, how can you successfully compete as an athlete at any level?

Our athletes have this in common wherever they live around the world: they all have a permanent intellectual disability; they all demonstrate courage on the athletic field and acceptance of others; they all get sick on occasion and have health challenges like everyone else; they care whether they are well or sick; when they get sick, they need care; when they have tooth infections they hurt, even if they

don't complain; when they get sick and can't get the care they need, they suffer and get sicker; when they finally do get care, too often it is as a last resort when their options aren't particularly good.

The way they differ from other people is that they tend to have few available resources for assistance; be underemployed or unemployed—thus, they tend not to have private medical care, including dental insurance; no one expects them to be pretty or handsome; no one expects that they need to have a bright white smile; no one really worries if they are missing some of their front teeth; no one knows if they have dental infections; no one knows if they are in pain from dental disease; no one, or hardly anyone, feels responsible for helping them to achieve oral health.

Allow me to lay out some hard facts for you. Special Olympics, through its Healthy Athletes' Program, provides free health assessments and some care to more than 130,000 Special Olympics athletes each year. We conduct more than 600 health screening events in some 70 countries through the volunteer efforts of 13,000 healthcare professionals and students, supported through the generosity of the U.S. Centers for Disease Control and Prevention, Lions Clubs International and several corporate and academic partners. And let me thank the U.S. Congress for appropriations directed to our Healthy Athletes Program over the past 5 years that makes this broader largesse possible.

We have accumulated across our seven Healthy Athletes screening disciplines, without a doubt, the largest database of health status and health needs of persons with intellectual disabilities that has ever existed. Our Special Smiles' screening protocol, one of the first disciplines implemented by Special Olympics, was established and validated by the U.S. Centers for Disease Prevention and Control nearly a decade ago. Over the past 5 years alone, Special Olympics has conducted 530 Special Smiles screening events around the world. More than half of them have taken place in the United States. We have provided about 12,500 dental screenings at those events to athletes age 8 years and older.

In this day and age, where dental art and science can produce almost any smile one could wish, consider the following. Of Special Olympics athletes (n=5447; average age 24 years) volunteering to participate in the Special Smiles Program in the United States:

- Some 12 percent report pain in their mouths at the time of the screening;
- More than a third have obvious signs of gingival (gum) infection;
- Nearly a fourth have obvious dental decay (without probing or x-rays);
- One quarter are missing teeth, reflecting end-stage treatment of common dental diseases (like Deamonte Driver);
- Too many have extensive dental plaque that leads to infection of oral tissues, hard and soft, and ultimately, loss of teeth;
- And, too many athletes and families report that they have never been able to secure a regular source of dental care for their child, even as nearly one in ten are in need of "urgent" dental care.

Further, Special Olympics, the sports organization, has done research into the preparation of dental and medical students in the United States to understand the scope and quality of their professional education in dealing with the health needs of people with intellectual disabilities. What did we find? The vast majority of dental and medical students do not feel adequately prepared to work with this population when they graduate from school. They say they want to be prepared, they just are not. Further, the deans of dental and medical schools and graduate medical and dental programs acknowledge that their graduates are unprepared to deal with the needs of this population. If you survey a listing of continuing professional education courses that address the needs of the intellectual disabilities population, you would be hard pressed to find any.

So, if healthcare professionals aren't trained during their basic professional preparation, and there is no marketplace for continuing professional education in this area, should we be surprised that people with intellectual disabilities and their families have difficulty in securing reliable, receptive, qualified sources of dental and other healthcare for their children?

Here is one of my most recent disappointments. In September 2005, Special Olympics created a Web-based directory of healthcare providers nationwide. That is, we created a user-friendly way for clinical providers in virtually all health disciplines to identify themselves to persons with intellectual disabilities and their families as willing to speak with them about the opportunity to receive health care. Not a guarantee to health care! Not a guaranteed price for health care! Just the opportunity to discuss the opportunity for healthcare.

After a year and a half of proactive outreach to professional organizations, we have fewer than 1,000 of the more than 1 million U.S. health professionals reg-

istered. Regarding dentistry, we have only 248 names listed (as of February 20, 2007) out of more than 150,000 dentists in America. If you were a person with intellectual disabilities seeking a chance to be healthy or a family with a child with intellectual disabilities, whom you worried about in terms of their health care, how would all of this look?

I can tell you that Special Olympics Healthy Athletes is special its own right. It is a place that athletes know is their place. And it is a place for volunteer healthcare professionals where, for example, a 40-year veteran of clinical healthcare delivery can say tearfully and happily, "Now I know why I invested 10 years in my professional education and all of that money learning how to care for people." In the end, one can say that it "ain't" brain surgery. But, for Deamonte Driver, it was brain surgery when it didn't have to be. When we do our Special Smiles dental screenings, in addition to examining the teeth and oral cavity, providing dietary and oral hygiene education, constructing mouth guards where appropriate and providing preventive supplies, we also provide our athletes with a report card on their health, as well as referral information for follow up where needed. Additionally, we provide lists of community dental providers—lists that are always too short or where the providers are not conveniently located. We do our best to get athletes connected with locally-based providers for follow-up care but, sadly, our lists fall short of provider information despite all our efforts.

Now, I need to share a compelling image with you. This is Mr. James Pierce. James is a person with a moderate intellectual disability. I can show you this picture because James gave us permission. James went to the dentist, Dr. Henry Hood of the Underwood and Lee Clinic in Lexington, Kentucky, a special dentist and friend of mine, with what you see. One does not have to be a dental professional to look at the picture of James and see that he is sick. There is obvious extensive dental disease, swelling around the eye, a contorted barely alive look. James did not get this way overnight. This is the accumulated neglect of years of lack of proper dental care combined with a lack of proper self care. Likely these problems started in childhood or adolescence and just perpetuated. The bottom line is that James was generally sick from dental infections. Is this a person who an employer would let interact with customers, or is this a person that "belongs in the back," if anywhere at all.

Look at James today and tell me what you see. Is this someone who can be confident in meeting people; someone who could work out in front? Is this someone who could succeed at some level? Is this someone you might be interested in knowing? Dr. Hood, a knowledgeable and caring dental professional, took the time to do an overall assessment of James and his oral health prognosis and provided the appropriate care. James is doing well and is employed. If James were your son, brother, friend, which treatment and care would you have preferred? I don't think we need to count the votes.

Can we muster the backbone to do what is right; to match our scientific knowledge with our social responsibility? Would we allow or condone those of minimal means to drive cars without seat belts because we might have to pay for them? Of course not.

Why would we sacrifice childhoods and even lives for failure to implement the most obvious of solutions?

Here are some suggestions that could help prevent future dental tragedies:

1. Change the culture around dental care for children. It should be as important as getting kids immunized or making sure they wear seat belts in cars. Dental care for children is universally needed.

2. The marketplace is not sensitive to many underserved populations as desirable business targets. That is, reimbursement levels in public programs have not been adequate to attract a significant increase in willing providers. In general, enhancements in public dental program reimbursement rates have been inadequate to achieve the behavior change in providers that is necessary. Reimbursement levels need to be enhanced to where they are market rational. Thus, we need to work to build opportunities that work toward full access to dental care for children. Strategies could include incentive payments for individual providers or community-based programs such as health centers when they reach target goals for providing care to high-risk populations.

3. Public oral health programs that are operated by government entities need to be designed to be proactive, not residual or reactive. It is not enough that a child is eligible to have dental care paid for. There must be a premium on children getting in for early and regular oral health care. Thus, public programs need additional resources, not just to pay dentists for care, but to provide a solid underpinning for a program that can produce real results in increasing access and reducing the prevalence of dental need.

4. Expand eligibility for children needing oral health care. Dental services should not be elective for States under SCHIP. And, programs should be designed with enough flexibility so that children are not constantly bounced off eligibility roles because of "hair trigger" provisions.

5. For special high risk populations, such as people with developmental disabilities, extra efforts are needed, including training of clinical providers and enhanced reimbursement provisions that reflect the additional time that is sometimes required in patient management and treatment. And, while we are at it, why is it that the population with developmental disabilities is not considered a "medically underserved" group by the Federal Government. That warrants some close follow up and future discussions by this committee. How is it that when a child with an intellectual disability hits a certain age, even though their disability condition is permanent, they "age out" of their Medicaid (EPSDT) dental benefits in most States to dramatically reduced "adult" service levels, if they are even available. Children with intellectual disabilities who are fortunate to receive care under Medicaid or SCHIP, all of a sudden get pushed out of the system—after years worth of investment of public resources in their care. This makes no sense at any level.

6. Provide needed quality oversight, research and evaluation of policies concerning dental care for children and vulnerable groups. This should be an ongoing responsibility of government. It is not enough to be responsive when a highly publicized tragedy takes place.

These suggestions are not complete, but, hopefully, can help point our collaborative efforts in the right direction.

"Deamonte Driver Saved"—"DDS." It is possible if we commit ourselves to the right actions. Thank you.

Mr. PALLONE. Thank you. Thanks a lot really for your testimony and for your insight.

That concludes our statements by the witnesses, so we are now going to now go to questions of the panel, and I will recognize myself to begin with that for 5 minutes.

We know that this hearing was brought about because of the story of Diamonte Driver in the Washington Post recently a few weeks ago and I think we all noted that this was a young boy who died from an infection that spread to his brain after his infected tooth went untreated. We also heard about another 6-year-old boy in Mississippi who recently died as well due to an infection that spread from an untreated infected tooth. Now, the pain that these families have to feel from losing a child is obviously enormous but our job is to make sure other families don't have to experience this tragic loss, and many of you have commented on that. I don't know all the details of Diamonte Driver but I know that his Medicaid coverage had lapsed and so certainly one of the issues would be about gaps in coverage. Some of you have talked about gaps in coverage and the need to shore up existing public programs. Others have talked about the lack of reimbursement rate. There are many factors that go into the problems that we are dealing with here.

I was going to ask Dr. Edelstein, I know you are a little bit familiar with Diamonte, if you could give us your assessment of how systems broke down to serve him and what could have been done to prevent this from happening by reference to him.

Dr. EDELSTEIN. Thank you for your question. The obvious and first-line systems failures are the ones that you have noted. Continuous eligibility would have made it possible for him to retain his Medicaid benefit even while in a homeless shelter. Care assurance systems that make sure that dental care is actually available and not just covered would have made sure there were places he could have gone, and all the various people who came in contact with him, the lawyers, social workers, people at the homeless shelter as

well as school nurses, teachers and others who have come in contact with him could have made referral, if there were a coordinated system of care in place that is already required by EPSDT legislation.

But then there is a secondary level of systems failures that are not as obvious, educational systems failures. So few parents yet know what NIH discovered 40 years ago, that tooth decay is an infectious and transmissible disease acquired by age 1 or 2 and that real prevention needs to start very early. Public information systems, work force systems many of you have mentioned that there is need for additional training. HRSA for example in its title VII program that Ms. DeGette mentioned does train pediatric dentists but it does not, as it does for physicians, allow curriculum development and faculty support, so those are systems that would address the problem Dr. Corbin mentioned about preparedness of our future dentists.

Early intervention systems—HRSA supports an early child comprehensive system that Mr. Scheppach mentioned relates to early childhood development. There is a place for early childhood oral health care there. And lastly, safety-net systems of care. The rural health centers, the community health centers, the school-based health clinics, they are all very, very small and the local community emergency room does not provide definitive care. So all of these systems had to come together for this monumental failure for these children.

Mr. PALLONE. Now, he was in a homeless shelter and their Medicaid coverage had lapsed from what I understand. I know they were covered by Medicaid. So this whole idea of continuous health coverage under Medicaid or SCHIP, breaks in coverage due to changes in income or whatever, I think that would come into play. I was just going to ask Dr. Roth because I know my time is running out, do you have any recommendations about maintaining coverage? We talk about continuous eligibility, a guarantee of coverage for a full year or presumptive eligibility, allowing a predetermination of eligibility. Did you want to comment on those gaps in coverage or ways to prevent that?

Dr. ROTH. There certainly are ways. It doesn't take anyone to figure out that you need to be continuously in a dental home to have good oral health and maintain your oral health. We strongly believe that a family has to become part of a dental system and you need to train the parents as well as get the children in for ongoing dental care. So it is simple. It needs the dollars to support the system and patients need access to get into that dental system.

Mr. PALLONE. You mentioned the reimbursement rate under Medicaid. Did you just want to comment briefly on that, I mean, because in his case, Diamonte's, it seems like there was a dentist that was able to take him but there was no coverage, but you seem to feel that there are other cases where the reimbursement rate becomes a block.

Dr. ROTH. Well, you do have many dentists around the country that are not Medicaid providers and the biggest reason for that is the reimbursement level is so low, it doesn't even cover the cost of overhead to provide the dental care. So I would encourage Congress to provide adequate funding of dental programs. And we are look-

ing to expand the system to provide another person on the dental team, the community health coordinator, which is simply a social worker, if you want to think of it that way, a person to go into the community that can do the social skills needed to educate the public as well as some clinical skills to their skill sets, if you will. So I would encourage you to look at our community dental health coordinator as another mid-level provider that can really answer the access issue from the community level as well as from providing care and clinical skills.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

I am going to move quickly and I would ask my witnesses to do the same, so if they could. First of all, Mr. Scheppach, the Governors I know supported the provision that was in the DRA allowing them the flexibility to provide benchmark plans for their Medicaid population. Recently the members of this committee received a letter from Governor Ernie Fletcher of Kentucky concerned about a provision that was originally in the Iraq supplemental and I think it was taken out in the final version that he felt would jeopardize that ability and that flexibility for Governors. Is that still an important issue, and if so, why?

Mr. SCHEPPACH. Well, yes, it is. I think we had a number of States, West Virginia, Idaho as well as Kentucky who have actually taken that provision and really tried to do some preventive care so that they can better manage long-term chronic illnesses, so that flexibility is still an important issue to Governors.

Mr. DEAL. Thank you.

Mr. Chairman, I would unanimous consent that the letter from Governor Fletcher be made a part of the record. I think we have all received copies of it.

Let me quickly move to highlight what I consider to be important here. Diamonte Driver is the case that we all cite as the reason we are here and I have heard a variety of things. I have read your testimony as I have heard your testimony. It all generally starts out with the system failed him, the systems failed him. I believe Dr. Edelstein just enumerated who failed him, the lawyers, the teachers, the social workers, the homeless shelter workers and everyone. I never heard the mother or the parents mentioned as the ones who failed him. In most of our households, we assume that responsibility as parents. If it lapsed, then whose fault was it? It wasn't the child's fault. It was the parents' fault for not signing up an eligible child. I wonder if we had had Diamonte dying from an internal bleeding that had occurred because he fell while he was in the mother's presence and he had died from that, we would have probably had a child abuse case brought against the mother but here we blame the systems. We never put personal responsibility in the equation, and I think it is an important ingredient that has been overlooked.

But let me hit some of the things I thought you ought to maybe elaborate on if we have time to do it. First of all is, we have heard reimbursement rates under Medicaid, under SCHIP, et cetera. One question I would have, are the reimbursement rates for dentists disproportionately less than for doctors treating in the medical en-

vironment, and is the ratio of dentists who are signed up in the Medicaid programs disproportionately low as a percentage of the dental population versus the medical enrollment there? Who would care to comment on that? Dr. Edelstein.

Dr. EDELSTEIN. I would be happy to. The answer to both of your questions is yes. The rates are lower relative to other providers but there are problems with Medicaid payments across the board. If you compare Federal Government rates for physicians in Medicare with the same services in Medicaid, you can see that differential.

But I want to take a moment to agree with you wholeheartedly about parental responsibility. There is no question. The question becomes when parents then do seek care, which is perhaps not the case we were addressing today but when parents then do seek care, are they able to obtain it. Too often the answer is no.

Mr. DEAL. Let me go to that because I think that is the next thing. The number of available dentists, I think Dr. Mosca's testimony is very informative as to dental schools, the number that are there, the number that are producing. I used the statistic in my State, we have 240 retiring every year, only producing 60 in my State dental schools, as I understand it. That is a huge problem, the number of available dentists. What do we do about that? Dr. Mosca, you are probably an expert on that.

Dr. MOSCA. Well, let me just make an additional comment. The child that I mentioned in Clarksdale who had the dental abscesses this past Friday actually had access to the care system but did not receive the treatment that the child needed, and so I would have to agree with Dr. Edelstein that——

Mr. DEAL. In fact, you point out that EPSDT mandates dental coverage for children and that only one out of every four children under Medicaid actually receives those services. Is that right?

Dr. MOSCA. Correct.

Mr. DEAL. OK.

Dr. MOSCA. But I think that in terms of the numbers, I think that the other layer that we add on to this is the knowledge and skills. For example, when managing the youngest and the oldest populations, we rely on the title VII residency training programs to impart that type of educational experience. It is important to understand how to treat young, young kids and elders because there are some issues that interface with the level of skills.

Mr. DEAL. My time is running out. Let me just enumerate some other things I think are important. The geographic distribution of dentists, many of you have alluded to that. The number of dentists who are available in community health settings or other clinic settings, I think all of those at distribution of services is a key ingredient and unfortunately, my time is up.

Mr. PALLONE. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and following up our ranking member, I think the actual case we are talking about, I think the mother did apply for the Medicaid extension. She lost it because she was in a homeless shelter and I think the paperwork may have gone back to a homeless shelter instead of her new residence. Again, my concern is that I have seen what happens. They are trying to expand Medicaid programs and SCHIP in a lot of our

States and they cut that expansion because they really don't want to sign up in the name of flexibility a lot more children.

Let me talk about, I am a longtime supporter of health centers programs and we have introduced legislation to reauthorize it until 2012. One of the key Federal requirements of health centers is they provide a full range of primary and preventive care including dental care. In fact, in 2005, health centers encountered 1.7 million visits for preventive dental exams. While the requirement to provide access to dental care can be met through referral arrangements, 73 percent of the health centers provide preventive dental care either onsite or through contracting arrangements.

Ms. Farrell, you mentioned health centers as recipients of infrastructure grants resulting from Michigan's dental taskforce recommendations. Can you or the other witnesses speak to the role health centers play in a safety-net dental provider?

Additionally, Dr. Edelstein, can you speak to the effectiveness of contracting arrangements between dentists and health centers and any recommendations you would have.

And lastly, Dr. Roth, when you talk about the community health coordinator in your testimony, that is not just a social worker, that is actually a provider that is licensed by the State to be able to do exams and things like that but also go out and do preventive health care. So it is a long question about how we can we better relate to health FQHCs with the dental requirement because my FQHCs, the few we have, it is typically pediatrics, a lot of children, and the children are the ones who need the dental care. You will have 3 minutes to answer that long question.

Ms. FARRELL. Yes. Along with my dental responsibilities, one of my responsibilities is also our community health centers, all our cost-based reimbursement policies, our safety-net providers, so I am very aware of the community health centers in the State of Michigan. I believe we have 27 federally qualified health centers with 155 sites throughout the State. Some of them are rural, some of them are urban, but the majority of them do offer dental care. When we offer these infrastructure grants, we did 32 sites. Out of those 32 sites, 15 of them went to, the grants went to community health centers so they expanded their dental operatories and we have our Medicaid population and the uninsured in our SCHIP, they treat all three of those. In addition, we have also partnered with University of Michigan and the dental students and we rotate students through community health centers to make them aware of what is available so we can try to get them to treat and come back and be providers into that community, which has developed into a win-win situation where we have had at least five or six dental students from the University of Michigan become providers at community health centers.

Mr. GREEN. Dr. Edelstein?

Dr. EDELSTEIN. Mr. Green, you mentioned that 73 percent of community health center grantees have dental programs but in fact it is far fewer sites that actually have programs and many of the sites——

Mr. GREEN. Mostly contracting, in all honesty.

Dr. EDELSTEIN. Right, and so what we end up with is a fair number of community health center sites that don't actually have the

capacity to deliver care, and you mentioned contracting as a solution for that. CMS, then HCVA, HRSA, the American Dental Association and the National Association of Community Health Centers worked on developing a contracting manual that would allow private dentists to provide services to community health center patients. What Congress needs to do is to clarify with the agencies that that in fact is legal to do because there has been controversy amongst the primary care associations. So with that clarification, that approach that you have recommended could expand dramatically.

Mr. GREEN. Dr. Roth, on the community health coordinator, and I know in your answer to another question you talked about a social worker, which is great, but also it is a provider. This person would be a provider?

Dr. ROTH. That person would provide clinical skills so they will do some—very many preventive services. They are not going to be a licensed provider so it is not another level of a dental hygienist or a dentist. It is not a licensed person. It is a person that will work under the scope and under the auspices of a dentist. In a community health center, they can work offsite so they don't need to have a dentist onsite necessarily to work. But they are not licensed, and I want to make that clear right from the start.

Mr. GREEN. OK.

Dr. ROTH. They will have an educational program that takes about 2 years and we have that ready to start this fall. So we are looking to pilot those community health coordinators and get them into community health centers and into schools beginning this fall in their educational programs. I would encourage Congress to look at possibly funding some of those pilot sites that we are looking to do. It is not a lot of money but it certainly will make an enormous impact in expanding the efficiencies of dental care that has reached into the communities as well as expanding the dental network of people that can provide care.

If I can just answer the community health center issue, less than 1 percent of all the practicing dentists, which is 162,000 practicing dentists in the country, are employed in a community health center. If we can expand that network by providing the dentistry that needs to be done by going into the communities and partnering and contracting out, as Dr. Edelstein promoted, that really is an answer to using a dental workforce that is out there available. They need to be compensated and need to be able to work, the work is the problem.

Mr. PALLONE. Next is Dr. Burgess.

Mr. BURGESS. Thank you.

Just to follow up on that, Dr. Roth, Mr. Deal referenced the large number of dentists that are retiring in Georgia every year. If we modify the Federal Tort Claims Act somewhat to allow those retired dentists to come into the community health centers and practice, would that not be a beneficial thing? Yes or no will suffice.

Dr. ROTH. Absolutely.

Mr. BURGESS. Thank you.

Let me ask Dr. Mosca a couple of questions because I really appreciate your testimony. I thought it was so critical and of course, Baylor College of Dentistry is down near my—not in my district

but near my area. They, as I understand, provide a significant amount of low-cost or free care, not just to children but to all patients, to all comers. Other schools provide the same service, I would assume? Dr. Mosca?

Dr. MOSCA. I am sorry. I thought you were talking to Dr. Roth.

Mr. BURGESS. The care provided by the colleges of dentistry, they play a big role I know in the Dallas area, Baylor College of Dentistry does and I have even heard from members of your profession coming to talk to me about nursing home patients who also pose some of these same problems and are typically underserved but a lot of this falls to the dental school. Is that not correct?

Dr. MOSCA. That is correct.

Mr. BURGESS. Well, do we have enough?

Dr. MOSCA. Do we have enough dental schools?

Mr. BURGESS. Correct.

Dr. MOSCA. Well, we actually have——

Mr. BURGESS. I asked you first.

Dr. MOSCA. We actually have a number of schools. There have actually been six new dental schools that are in the process of opening. The Arizona School of Health Services, the University of Nevada-Las Vegas opened in 2002, Nova Southeastern University in 1997, and actually there is a predicted decrease in services up until I think 2020 and then at that point there will actually be an increase in providers, and that is because of closing of schools that occurred a while back, so we are kind of trying to catch up with the closure of the previous school but these new schools should add to the workforce.

Mr. BURGESS. We have reached the nadir, but of those people that are going to be entering the workforce, do we have a concept of how many will be entering pediadontics and general dentistry as opposed to the higher reimbursement subspecialties of dentistry?

Dr. MOSCA. About half of the graduates, I mentioned that 4,500 graduates are released each year, and about half, or 2,800, go into either general dentistry or some specialty training.

Mr. BURGESS. Tell me this——

Dr. MOSCA. The title VII funding actually does allow the dental schools to increase and support that type of training.

Mr. BURGESS. My observation has been that most people go into the practice of medicine close to where they trained because they know the community and they know the other providers in the area. Is the same true of where dentists choose to practice?

Dr. MOSCA. In Mississippi, about 70 percent of our schools' graduates have stayed in the State.

Mr. BURGESS. So they do tend to stay close to home. What type of location decisions are made based on the prospects of perhaps low reimbursement or a population of low health literacy where the outcomes may not be as good?

Dr. MOSCA. That is actually an issue that we are trying to solve within the State of Mississippi. By working with community partners, we are trying to incentivize providers to locate in various areas. I was just at a meeting 2 weeks ago——

Mr. BURGESS. If I can interrupt you, how do you do that? How do you provide that incentive?

Dr. MOSCA. At the meeting I was at 2 weeks ago, we had the mayor, we had the county supervisor. We convened the local civic leadership to actually——

Mr. BURGESS. So the community provides some of that incentive?

Dr. MOSCA. To try to, right, for——

Mr. BURGESS. Pardon me for interrupting, but the chairman has an iron fist with that gavel and I have to ask some other questions.

You were starting to reference data reporting in your testimony. What type of data do you want to see and what will you do with the data as you collect it?

Dr. MOSCA. Well, the data that we have collected has been very helpful in promoting discussions around policy and I would have to concur with Dr. Edelstein that we need to look at the outcomes of the SCHIP programs and capture that data.

Mr. BURGESS. And when will that type of data be available to us here on this side of the dais?

Dr. MOSCA. I can't answer that question but I could certainly provide that answer for you.

Mr. BURGESS. And I think the committee would genuinely appreciate that.

Let me go with what little time I have left to Dr. Scheppach. Governor Warner sat at that very table about a year and a half ago and said that Medicaid was on the road to a meltdown because of the costs and the expansion of costs of the Medicaid program. Do you think that statement is still valid today or have we fixed it?

Mr. SCHEPPACH. Yes, I do. Even though the growth in Medicaid——

Mr. BURGESS. We fixed it?

Mr. SCHEPPACH. No, we did not fix it.

Mr. BURGESS. And you talked about some of the coverage initiatives that are going on in States to affordable health insurance and you kind of ran out of time there and you are going to run out of time again, but can you kind of explain how Medicaid and SCHIP fit into these State initiatives?

Mr. SCHEPPACH. Well, I think it is important to maintain the flexibility that we currently have because I think the key component of this is that the States are creating connectors for the small market.

Mr. BURGESS. And do you think that the flexibility that we provided has allowed those States, Massachusetts, California, to some degree even Texas to begin to tinker with those and provide those types of benefits?

Mr. SCHEPPACH. That is right, and that is a benefit that you can also provide to small business and so on. You can stabilize that small market. If you start doing independent additional benefits, it is going to create an obstacle.

Mr. BURGESS. Thank you.

Mr. PALLONE. Thank you, Dr. Burgess.

Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

I was sitting here thinking about how important pediatric dental care is and how it can really prevent so many bigger problems, not just in the long run but immediately, so I had my staff pull the SCHIP statute. It is always dangerous when the members of Con-

gress start actually reading the statutes, and one of the required coverages right now under SCHIP is well-baby and well-child care including age-appropriate immunizations. That is required in all 50 States right now. And so when I look at that, it seems to me that dental care should be included in that, and so then I was reading Mr. Scheppach's testimony about how you think that flexibility should be maintained with the States in pediatric dental care under SCHIP. I wanted to ask you a couple of questions about that, because in reading your testimony, it seems that the main flexibility you are talking about, Mr. Scheppach, is flexibility in how that dental care is offered. Would that be accurate? I mean, you are not really saying on behalf of the Governors that we should allow States flexibility in whether to offer pediatric dental care, just in how they deliver that?

Mr. SCHEPPACH. Well, I think right now it is an optional benefit, and I think what we are saying, it should probably continue as an optional benefit.

Ms. DEGETTE. Well, it is an optional benefit right now but all of the States up until now have offered dental care, correct?

Mr. SCHEPPACH. That is right, but they have different restrictions essentially on how much they are willing to do, the number of treatments and that type of thing.

Ms. DEGETTE. Right, but Mr. Green and I are both concerned about this because his State of Texas is now talking about dropping dental care for cost concerns and other States like Colorado and others have talked about it too. So I think we can all agree, all the whole panel agrees that pediatric dental care can be very cost-effective as well as humane for the kids, right?

Well, I will ask you, Dr. Edelstein. Pediatric dental care can be very cost-effective and also humane for the kids?

Dr. EDELSTEIN. Cost-effective, humane and essential. I cannot understand how the mouth can be carved out of the rest of the body and put restrictions on how much care. It is like saying that we can diagnose a problem but not treat it. We can do $175 worth of your appendicitis but we are going to stop there and just close you up because we have hit the benefit. It is the only service that is treated as though it weren't part of the child's body.

Ms. DEGETTE. Well, and actually that is the other thing. Just getting back to Mr. Scheppach though, I understand your point about flexibility and how you offer it but if all the States are doing it now, I don't suppose there would be a big objection by the Governors if we just said you have to offer dental care under SCHIP but still allowed from flexibility.

Mr. SCHEPPACH. Well, I think what would happen essentially is that wouldn't allow flexibility, you would set certain standards around that benefit package and that would be relatively costly and it would be hard to package it in managed care and combine it with health care benefits so it is not—I don't think the legislation would ever say provide health care benefits. You would put certain standards around it in terms of the numbers of visits and what is applicable.

Ms. DEGETTE. Well, all the States offer dental so there is going to be conditions around that. Now, I would really hope the Governors association would work with us as we reauthorize SCHIP

because if everybody is offering dental and if what Dr. Edelstein says is true, and we all believe it, which is dental care is essential to this and it is also cost effective, I think it would be my inclination and I bet you I can speak for a lot of my fellow panel to include it but we do want to allow the States flexibility to make it work.

Dr. Edelstein, I wanted to ask you another question, which is related to what you just said about the idea of dentistry being related to the whole body. I think maybe based on my experiences, the mother of two—I was watching Mr. Pallone's kids. We have had many investments not only into pediatric dentistry but also orthodontia, which are ongoing to this date, but I think a lot of parents even in my socioeconomic bracket don't realize the importance of pediatric dentistry and of taking their kids to the dentist on a regular basis. Would you agree with that?

Dr. EDELSTEIN. It does vary significantly across populations by education and by opportunity and by their own experience but certainly the value of pediatric dental care is something that has only grown in awareness in recent years.

Ms. DEGETTE. So for someone to blame the mother of this young boy who died from an abscessed tooth who was living in a homeless shelter, I think that is kind of an unfair placement of the blame. I don't know if you have a comment on that.

Dr. EDELSTEIN. The only comment I have is specific to this particular child and that is that his presentation was one that did not scream out initially dental abscess. It took the skills of diagnosticians of dentists and physicians together to identify the original cause of this problem and that is an indication of how complex it can be and how the teeth are indeed part of the body. Symptoms can show up differently than expected.

Ms. DEGETTE. And I would also say I think we need to have a global—this is a topic for maybe later today or another day. We need to have much more public awareness of the importance of pediatric dentistry across all socioeconomic groups.

Dr. EDELSTEIN. Particularly starting at age 1 as recommended by the pediatricians and by the pediatric dentists because that is when the disease begins.

Ms. DEGETTE. Right. Thank you very much.

Mr. PALLONE. Thank you.

Mr. Murphy of Pennsylvania.

Mr. MURPHY. Thank you, Mr. Chairman.

A couple quick questions. I know in my role as a psychologist for many years I would sometimes be contacted by dentists who felt that a child because of their substantial learning problems or behavior problems might require some extra care in preparation for a dental visit, but I must admit I am not clear on whether or not these things are handled appropriately by any payments in the SCHIP program or Medicaid or anything else. Can someone comment on these sorts of needs and is that something that the reimbursement rates are also not adequate to handle?

Dr. ROTH. I can comment on that. You are right, there are some children that do have special needs whether it is hospitalization for extensive dental care or simply a mild sedative to make the procedures easier, and there is not coverage for that in most States.

Mr. MURPHY. So that is an expense the dentists themselves have to take care of out of their own pocket in order to do that?

Dr. ROTH. Yes, or the parents choose not to use comfortable means to deliver the dental care.

Mr. MURPHY. Which of course can mean child's dental care is even more aversive.

Second, there have been some things written in the paper about the amount of paperwork and bureaucracy that is necessary for a dentist to fill out if they want to participate in these programs. Are these really mountains of paper? Can someone comment on that? What do we have and is there a way of making it more effective? I see Ms. Farrell reaching for her button. Yes?

Ms. FARRELL. We have heard those complaints for a number of years in Michigan. We have tried to address that administrative burden. We have streamlined our provider enrollment form. Of course, with HIPAA and the administrative simplifications, we have had to go to national code sets. We are going to national claim forms, which is the ADA claim form, the paper claim form or electronic version. So there are lots of steps that we have tried to, and I would say the majority of States speaking also in my Medicaid/SCHIP dental association role. We have all looked at trying to decrease that administrative burden on the dentists to try to get them to become participants.

Mr. MURPHY. I would hope that could all be simplified.

Dr. Roth?

Dr. ROTH. Well, if I can just add to that quickly. It is not simply signing up to be a Medicaid provider but it is the claim forms that you have to fill out when you try to provide the services. They are not using the standard ADA claim form, which I use for all my other insurance company forms, so they make the system much more difficult than it needs to be.

Mr. MURPHY. Do they allow for any electronic forms on this——

Dr. ROTH. They do, but it is also very difficult to get into that entire system from the Medicaid system itself.

Mr. MURPHY. I know whenever I would fill out forms too, I would always ask myself how much of this information is really necessary to make a decision on whether or not to cover this child, and outside of the name, I am not sure how much anybody really reviewed.

Let me ask another question here. A comment was made earlier about 73 percent of community health centers offer dentistry in them. How much of this is really—I mean, just to have someone there doesn't necessarily mean they can take care of all the demands and needs.

Dr. Edelstein, can you perhaps comment on, I had seen previous studies that talked about a shortage of psychiatrists, internists, family physicians and OB/GYNs at community health centers. What is the shortage of the demands versus what we have needs for there with dentists at community health centers?

Dr. EDELSTEIN. Yes, let me please clarify that 73 percent. That is 73 percent of health center grantees but many grantees have multiple sites so if one site has a dental program and five or six additional sites do not——

Mr. MURPHY. So that could actually be a skewed upward number?

Dr. EDELSTEIN. Very much so.

Mr. MURPHY. OK.

Dr. EDELSTEIN. And it is really estimated that it is closer to half of community health centers have a dental program——

Mr. MURPHY. So they may have a dentist there but can they fill the needs of the patients who need them?

Dr. EDELSTEIN. Absolutely not. The community health centers have prioritized relative to children. The community health centers in many States have chosen to prioritize uninsured adults who have no other recourse whereas children do have Medicaid coverage. Medicaid coverage for adults does not include dental services in the majority of States so the community health centers become the site of service of last resort for adults. That has crowded out the kids.

Mr. MURPHY. One of the things that I love about community health centers is unlike I think any other thing we have in pediatrics, it is in one building where everybody knows each other, where at the moment a pediatrician, for example, can be meeting with the family, he can say let me introduce you to the dentist who we are going to make another appointment for or the psychologist or social worker or someone else to do that, which is a huge asset. I had mentioned my bill before, H.R. 1626. I doubt if you have had a chance to read it, but I hope you would take a look at that in that it really does allow physicians and dentists and others to volunteer. Have you ever taken a poll of how many dentists semi-retired or active would be willing to give some of their time? Does anyone know that?

Dr. EDELSTEIN. I don't think that figure is known but it is part of the volunteer solution, but as we recognize, charitable care and volunteer care is not a system of care but it can be part of a gateway into contract care in private offices that would work very well for the majority of FQHC patients.

Mr. MURPHY. Thank you very much.

Mr. Chairman, thank you so much.

Mr. PALLONE. Thank you.

Mrs. Capps.

Mrs. CAPPS. Thank you again. This has been a very fruitful panel. I just hope we can pick up on a lot of these things. Our ranking member asked some very pointed questions about parental responsibility, which I appreciate, and that is one of the topics, the areas that I think we should go into. I just recall from my days as a school nurse with parents so concerned about what to do about this child in pain crying out in the night. That certainly was a high priority for them. In many parts of my district, most of my district at that time, it was over 100 miles to go to a dentist who would take Medicaid. A pediatric dentist was even further and the waiting lists were months and months long. I know some steps have been taken to remediate that but I also know parents would be so motivated, they would take whatever cash they had and go to the dentist in the Yellow Pages and wouldn't have enough and then it is rent or food. I mean, these are really tough choices for many of our families.

Dr. Edelstein, I wanted to give you a chance to expand on your points about prevention, overall well-being and the cost-effective-

ness of early dental care for children. It always pained me as a school nurse to see kids losing so much valuable class time and not able to concentrate on their studies. Can you share any information about how often oral disease accounts for absenteeism, and the reverse, what are the ways that you can document that it is important to a child's participation in education?

Dr. EDELSTEIN. I think your point earlier that many children are in the classroom but distracted, they are in the classroom but unable to focus, they are in the classroom but feeling dental pain intermittently that really does cause them to act out and not perform well as students, and that dental pain doesn't go home when they go home from school. It only becomes a problem throughout the day, and that kind of chronic distraction long before we get to the kind of infection that we have been talking about earlier.

But you did mention cost-effectiveness of prevention and I wanted to cite a couple of statistics about the tremendous cost-effectiveness so that the Governors and others will consider how much benefit can be gained and cost savings can be made rather than new expenditures in the Medicaid and SCHIP program. One recent study from the University of North Carolina pointed out that children who start care at age 1 as currently recommended by pediatricians and pediatric dentists, over the next 5 years consume 40 percent less cost for care than had they not started at age 1 and they utilize the emergency room less. That is dramatic. Children with coverage are 30 percent more likely to get preventive care, and routine care instead of emergency care. That Texas study that was illustrated in my slide shows that the average cost for an admission over a period of multiple years in Texas at discounted rates paid to the hospital by Medicaid was $6,500. The emergency room visits were $230 for the same kind of presentation but resulted in no definitive care, and the same kind of care could have been provided in a dental office for somewhere between $50 and $80. So the opportunity to utilize the lowest cost, most effective, most preventive site is often overlooked.

Mrs. CAPPS. Just to wrap this up, we have this opportunity, a unique one as we reauthorize SCHIP, I don't want us to lose that change. This is the kind of data then that we can have to help us understand that access to dental care is really cost-effective. Do you want to just expand further and then I will open it up if there is——

Dr. EDELSTEIN. Well, it is our pleasure at the Children's Dental Health Project to provide these kinds of data. Almost all of them are derived from Federal studies. Those that are not are derived from State studies and some from university studies. We have well-reliable information that can help make sound policy.

Mrs. CAPPS. Anyone else want to pick up on that for the last 45 seconds? Thank you.

Dr. ROTH. I would just like to encourage you to have States look at those models of care that are successful. You have got the Michigan model and you have got Smile Alabama and TennCare. You have got some great programs out there that are working and working very well for the children and the providers in the States. It doesn't take that much more money but it is money that is used wisely in combination with government and the dental community

all coming together. So I would encourage you to make that part of your mission, adequate funding, and then look at the models that work.

Mrs. CAPPS. Thank you very much. I will yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Tennessee.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you to each of you for your time today.

Dr. Scheppach, I would like to come to you, if I may, because I appreciated your testimony, and even though your testimony ran long, I love the fact that you have a great enthusiasm for what you do and that you seem to have such a heart for being certain that the programs work well for our State. I think that that is the area where the rubber meets the road and our States and our health care agencies within our States are the ones that are working with those local communities and keeping the focus on how we preserve access to health care and how we preserve access to those components of a healthy lifestyle that our constituents all want, and I noted in your testimony, you had made a statement, if the States are required to meet new Federal benefit mandates in either Medicaid or SCHIP, they will have to spend more money per individual currently covered in these programs. Increased costs will force the States to redirect funds that could have been used to fund other affordable health insurance initiatives, and many times I think those of us at the Federal level who look at how we structure a program forget that any time there is a mandate that goes out, that is paperwork for the provider, it is paperwork for the insurance company, it is paperwork for the State that is the conduit to those funds, and when you put that money into paperwork, it is not going into health care, and what I want to do is have you speak a little bit to flexibility and your concerns about reducing flexibility in these programs and the impact you see that a reduction in flexibility and increases in mandates, what that would do to our States and some of the innovative programs.

Mr. SCHEPPACH. Well, as I indicated before, I think we are at a basic tipping point with respect to States moving forward and actually doing comprehensive health care reform. I think that within the next 2 to 3 years, we have already had four who have enacted it, I think we will have 6, 8, 10 more that will enact it. Some of those will be big States. We will begin to find out whether personal mandates work. We will begin to find out whether employer mandates work, whether connectors work and so on. I think that the root to national reform is through the 50 State houses and we are only going to be able to get Federal reform after we prove what works at the State level.

With respect to the mandates, again, you would like to make a basic public policy decision, are we going to try to have a basic benefit package for the entire population, get everybody in with some level of coverage or are we going to make a decision to leave a whole bunch of people out and create a more robust benefit package for certain populations. We talk a lot about quality in these particular programs. I think we need quality standards across the board in health care and dental, not necessarily for the SCHIP program but for the entire thing. What we are doing is setting stand-

ards around individual programs, which means we keep selective programs operating rather than trying to get at an efficient market. What we need to do is let the States move forward, help them to get everybody in the system, work out the bugs, because I think they will give a direction for national health care reform. When you put on specific benefit mandates, States aren't going to be able to get universal care. So I think you have to make a policy choice: are we going to get to universal more quickly and allow the States to provide the leadership or are we going to provide more robust benefits for certain populations.

Mrs. BLACKBURN. So what you are saying is, we have got the four States that have programs out there that are exercising some innovation and you have got six to eight States that you feel like are going to be ready to move forward and implement programs but if we come in with the mandates and change the structure, then all of that work just goes out the window?

Mr. SCHEPPACH. I would say it makes it more difficult. I think there are other places that the Congress can help. I think we need help on sort of setting up alliances or connectors. I think we need help on sort of quality measures, price transparency, health IT. We need to set up an infrastructure so that consumers can make decisions around this rather than concentrating on expanding an individual program.

Mrs. BLACKBURN. Those initiatives that you just mentioned, those items that you just listed where you need help, are any of the States leading on innovation in those specific areas?

Mr. SCHEPPACH. A lot of States are. Yes. I mean, the health IT, we have been working with HHS. We have made contracts to 35 States to work with their stakeholders in those particular States so that they can deal with the security issues, the confidentiality issues and so on. So all of these areas we have got States moving: quality, price transparency, health IT.

Mrs. BLACKBURN. Anybody else want to add something to that before we leave that? My time is about up.

Dr. Edelstein, go ahead.

Dr. EDELSTEIN. Yes, I appreciate the opportunity. Thank you. I completely agree with Mr. Scheppach and with the Governors that basic health care should be the goal, basic health care and not extra benefits. I am simply saying as we discussed yesterday that dental care is a component of basic health care and agreeing with Ms. DeGette that well-child, well-baby care inherently must include oral health care.

Mrs. BLACKBURN. I yield back.

Mr. PALLONE. Thank you. And that concludes all questions for the first panel. I want to thank you all. I thought it was very insightful and thank you for your participation. We appreciate it.

I would ask the next panel to come forward. I am going to ask our second panel to be seated so we can continue. And again, I am going to introduce you all. Welcome. From left to right, we will get all our signs in place. First on my left is Dr. David Krol, who is the associate professor of pediatrics and chair of the Department of Pediatrics at the University of Toledo College of Medicine in Ohio, and second is Dr. Jack Chapman, who is president of Health Access Initiative from Gainesville, Georgia, and then last but not

least is Ms. Chris Koyanagi, who is policy director for the Bazelon Center for Mental Health Law here in Washington, DC.

I think you heard before that we are going to ask each of you to speak for 5 minutes. You can include your written statement for the record and we of course may ask for additional written questions to follow up afterwards as well. So I will start with Dr. Krol, if you would, for 5 minutes. Thank you.

STATEMENT OF DAVID M. KROL, M.D., M.P.H., F.A.A.P, ASSOCIATE PROFESSOR OF PEDIATRICS, CHAIR, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF TOLEDO COLLEGE OF MEDICINE

Dr. KROL. Thanks very much.

As a pediatrician, a general pediatrician who has worked very closely with dentists and mental health professionals, as the chair of the department of pediatrics and as a member of the American Academy of Pediatrics, I and we consider children's dental and mental health an integral part of well-child care and ensuring the bright futures process. We applaud the committee for holding this hearing.

The prevailing adult acute care model of coverage inappropriately limits preventive and other types of services that are of critical importance for children and adolescents because of their unique characteristics and environments. If we as a society can commit more than $2 trillion of our 2007 GDP to health care, there is no excuse or plausible explanation why our youngest citizens cannot have the best we have to offer that utilizes the clinical values of pediatric health care, training and research in its ultimate development. Because many adult diseases appear in childhood, investing in preventive benefits for children is also cost-effective. However, this return on investment can take many years to become apparent.

Through regular contact with parents or guardians, pediatricians and other child health care providers can assess and monitor a child's development and screen for developmental problems and risk behaviors. Although each child develops at his or her own pace, all children progress through an identifiable sequence of physical and emotional growth and change. Age-appropriate health care visits foster positive parenting behaviors, help promote optimal development and initiate early intervention when problems appear imminent.

The major risks to children's health and development, particularly after infancy, are largely preventable. Well-child care or health supervision provides a vehicle for health professionals to promote healthy lifestyle choices, monitor physical and behavioral pathology and provide age-appropriate counseling or anticipatory guidance.

Because of the prevalence of obesity, dental caries, attention deficit disorder/hyperactivity, depression and the stresses faced by parents, experts have noted that the term "well-child care" is applicable to fewer and fewer children. Pediatricians reported in a national survey that they face an array of obstacles to providing quality well-child care: time constraints, low levels of payment for pre-

ventive pediatric care and lack of payment for specific developmental services.

Optimal relationships between pediatrician, their patients and the patient's family occur in a medical home. A medical home is not a building, house or hospital but rather an approach to providing comprehensive primary care. A medical home is primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them.

In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics and other urgent care facilities, though sometimes necessary is more costly and often less effective. Children from low-income families are more likely than other children to have serious health problems. There is also an inverse correlation between poverty and education needed to manage these problems. While most pediatricians provide care for such families in their practices, financially they are being forced to limit the number that they can continue to see. One such practice in my home State of Ohio also takes care of 500 Medicaid children from Indiana. They have just notified Indiana that they are dropping their patient caseload to 90. While they are retaining the patients that have the most complex problems, the others will need to be reassigned. The reality is that having a Medicaid/SCHIP card does not guarantee access to quality pediatric care in a timely fashion. Needed modifications in payment could quickly rectify this situation.

The knowledge and science of healthy child development is a rapidly evolving field and the practice of pediatrics changes accordingly. Launched by the Health Resources and Services Administration's Maternal and Child Health Bureau in 1990, Bright Futures is a national child health promotion and disease prevention initiative that provides principles, strategies and tools that can be used to improve the health and well-being of all children. A comprehensive revision of Bright Futures is near completion by the American Academy of Pediatrics. The experts drafting the recommendations have established priorities for each well-child care visit to use as a guide in discussing health promotion and disease prevention with families. The first priority for every visit is addressing the concerns of the family around the health and development of their child.

Dollar for dollar, providing better health care for children represents one of the best returns on investment available. This wise investment means ensuring that health care systems including safety-net providers and health insurers are responsible to the unique health needs of children. As a Nation, we must invest in improving children's access to quality care. Just as coming events cast their shadows before them, so does the health of a nation's children foreshadow the health of its future.

Thank you for the opportunity.

[The prepared statement of Dr. Krol follows:]

American Academy of Pediatrics

STATEMENT

David M. Krol, MD, MPH, FAAP

Chair, Department of Pediatrics
University of Toledo College of Medicine

Testifying on behalf of the

AMERICAN ACADEMY OF PEDIATRICS

United States House Energy and Commerce Committee
Subcommittee on Health
March 27, 2007

Insuring Bright Futures: Improving Access to Dental Care and Providing A Healthy Start for Children

Department of Federal Affairs
The Homer Building
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005
202-347-8600 / 800-336-5475 / FAX: 202-393-6137

The American Academy of Pediatrics (the Academy) is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, who are deeply dedicated to the health and well-being of all children, adolescents and young adults. The profession of pediatrics is as concerned with promoting children's health and development as it is in treating their illnesses. The Academy considers children's dental and mental health an integral part of well child care and insuring bright futures process. We applaud the Committee for holding this hearing to highlight the needs of our youngest citizens.

The prevailing adult, acute-care model of coverage inappropriately limits preventive and other types of services that are of critical importance for children and adolescents because of their unique characteristics and environments. If we, as a society, can commit more than $2 trillion of our 2007 Gross Domestic Product to health care, there is no excuse or plausible explanation why our youngest citizens cannot have the best we have to offer that utilizes the clinical values of pediatric health care, training and research in its ultimate development. Because many adult diseases appear in childhood, investing in preventive benefits for children is also cost effective. Unfortunately, this return on investment can take many years to become apparent as costs of acute treatment are avoided.

Through regular contact with parents (or guardians), pediatricians and other child health care providers can assess and monitor a child's development and screen for developmental problems and risk behaviors. Although each child develops at his or her own pace, all children progress through an identifiable sequence of physical and emotional growth and change. Age-appropriate health care visits foster positive parenting behaviors, help promote optimal development and initiate early intervention when problems appear imminent.

The major risks to children's health and development, particularly after infancy, are largely preventable. In fact, the leading cause of death for children over age 1 is injury, including motor vehicle crashes, firearms, and drowning. Well-child care (or health supervision) provides a vehicle for health professionals to promote healthy lifestyle choices, monitor physical and behavioral pathology and provide age appropriate counseling (or anticipatory guidance).

Well-child visits are the hallmark of preventive care for children and provide the primary opportunity for prevention or early intervention for the vast array of developmental and behavioral problems. Because of the prevalence of obesity, attention-deficit disorder/hyperactivity, behavior disorders, depression, adolescent risk behaviors, and the stresses faced by parents, experts have noted that the term "well-child care" is applicable to fewer and fewer children. Pediatricians reported in a national survey that they face an array of obstacles to providing quality well-child care: time constraints, low levels of reimbursement for preventive pediatric care, and lack of reimbursement for specific developmental services.

In the United States, the quality of preventive care—commonly referred to as well-child care—is highly variable. Despite the commitment of considerable time and resources by physicians and other child health professionals, too many children and their families do not get the care they need.

Optimal relationships between pediatricians, their patients and the patient's family occur in a medical home. A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the medical home. In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective.

Children from low-income families are more likely than other children to have serious health problems. There is also an inverse correlation between poverty and the education needed to manage these problems and/or other risk taking behaviors. While most pediatricians provide care for such families in their practices, financially they are being forced to limit the number that they can continue to see. One such practice is in Ohio that also takes care of 500 Medicaid children from Indiana. They have just notified Indiana that they are dropping their patient caseload to 90. While they are retaining the patients that have the most complex problems, the others will need to be reassigned. Having a Medicaid/SCHIP card does not necessarily provide access to quality pediatric care in a timely fashion. Needed modifications in payment could quickly rectify this situation.

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Dollar for dollar, providing better health care for children represents one of the best returns on investment available. This wise investment means ensuring that health care systems – including safety net providers and health insurers – are responsive to the unique health needs of children. As a nation, we must invest in improving children's access to quality care. Just as coming events cast their shadows before them, so does the health of a nation's children foreshadow the health of its future.

Mr. PALLONE. Thank you, Dr. Krol.

Dr. Chapman, I know it says Mr. Chapman but it also says you are a doctor so I am going to use that. You are a medical doctor, correct?

Dr. CHAPMAN. Yes, sir. That is correct.

Mr. PALLONE. Thank you.

STATEMENT OF JACK CHAPMAN, M.D., PRESIDENT, HEALTH ACCESS INITIATIVE

Dr. CHAPMAN. Mr. Chairman, honorable members of the committee, thank you for allowing me the opportunity to address you today. My name is Dr. Jack Chapman. I am president of the Health Access Initiative in Gainesville, Georgia. I am also in the private practice of ophthalmology and I currently serve as president-elect of the Medical Association of Georgia.

I come before you today to share the story of how we are providing for the health of the low-income uninsured in Hall County, Georgia, especially children. We have a collaborative effort between private physicians, the Good News Clinic, the Hall County Health Department, the Health Access Initiative and the Northeast Georgia Medical Center.

What I would like to convey to you is how the old model worked and explain the new model now operating in our community.

Good News Clinics was founded in the early 1990's. It is the largest free clinic in the Southeast and one of the top 10 free clinics in the Nation. Largely with volunteer physicians, they provide free medical and dental care including medications to low-income uninsured patients. This is accomplished through a freestanding pharmacy staffed by a full-time pharmacist. In 2006, there were 8,843 medical clinic patient visits, 7,440 dental clinic visits and 66,451 pharmacy visits. The medications they provided to the patient at no charge had a retail value of $3.8 million. Hall County has a population of over 170,000.

The Hall County Health Department provides a prenatal program in conjunction with the Longstreet Clinic, a private multispecialty group. Prenatal care helps decrease infant mortality and infants' risk of health problems that would cost far more without prenatal intervention. In 2004, Hall County's infant mortality rate was 5.5 percent compared to 8.5 percent for the State of Georgia.

The Hall County Health Department also provides clinical services with 29,737 clients served in 2006.

In collaboration with community partners, Health Access Initiative provides access to health care for uninsured patients. Health Access is a consortium of partners including over 150 physicians, the local hospital, health department, free clinic, federally qualified clinic, United Way 2–1–1, chamber of commerce and other partners. This group came together to primarily fill the need for the specialty surgical care for the uninsured indigent.

Health Access adds value to the existing resources in the community by providing specialty and surgical needs in a seamless manner. Under the old model, when someone needed surgery, the physician seeing the patient at the Good News Clinic or the health department would be in a predicament. The physician would have to stop what he or she was doing and take the time to make a num-

ber of phone calls in order to find a specialist surgeon that would do a favor for the clinic. If surgery was indicated, the physician who was doing the clinic a favor would have to call an anesthesia friend and ask that physician to do a favor for him. If radiology was needed, then the same would take place. Of course, the hospital operating room would need to be contacted as well, and this does not include the challenge if more than one specialty surgeon is needed as well. Under the old model, it was a cumbersome, time-intensive process without structure, organization or measurement.

Health Access arose out of the Hall County Medical Society. What it accomplished under the new model is to bring all the participants together in a more coordinated fashion. We have the physicians, hospital, X-ray and labs all agree to provide the care for qualified patients on the front end. This way when a patient is seen in the Good News Clinic that requires specialty care surgery, the physician there makes the determination and writes the order. In the new model, Health Access is notified and contacts the patient to make all the arrangements. A photo ID is issued to the patient to identify them as the Health Access patient using a customized software tracking program. If anesthesia is required for surgery, they are already committed to provide the care. The hospital is already on board to provide labs and OR. Also, the radiologist is on board. The new model is seamless and user-friendly. It is also less of a burden for the volunteer physician and allows the physician to see more patients.

To track this, the physician's office providing the care sends a health claim form over to Health Access with the CPT code, the ICD9CM code, and the amount of services or care provided. We then enter this into our client tracking program so that we can track the care provided as well as how much was provided. We make sure that the patients keep all appointments and follow-up visits. Last year we documented a 90 percent compliance rate with patients keeping their appointments in the physicians' offices. According to the code, we track the value of services provided. In 2006, Health Access Initiative physicians in Hall County provided over $815,000 in donated care.

The emergency room is another entry point into our system. Our ER in Hall County is the third busiest in the State of Georgia with over 95,000 visits last year. When you think of an ER, you think of trauma, motor vehicle accident, heart attack. However, the No. 1 diagnosis in our ER is earache. The ER is used as a clinic. The cost of taking care of a patient in the ER as opposed to the office/clinic setting is three times. The Good News Clinic has data that shows their cost of care for a patient is $34 as compared to $221 for the same patient in the ER. The Andrew Young Health Policy Center at Georgia State University——

Mr. PALLONE. Dr. Chapman, you are about a minute over, so if you could summarize.

Dr. CHAPMAN. In closing, as you can see, it takes a lot of collaboration to make this work. The new model accomplishes this task. In fact, the Health Access Initiative was honored for this.

I hope that you will recognize that individual communities can step up to the plate to provide their citizens in need. I hope you will continue to encourage and assist as possible. The donated care

model is not the answer to the problem of providing health care but is part of the answer.

I thank you again for allowing me to be here today and I thank you for your time, service and attention you are giving to this very important issue.

[The prepared statement of Dr. Chapman follows:]

TESTIMONY OF JACK M. CHAPMAN JR., M.D.

Mr. Chairman, honorable members of the committee, thank you for allowing me the opportunity to address you today. My name is Dr Jack Chapman. I am President of the Health Access Initiative in Gainesville, GA. I am also in the private practice of Ophthalmology and I currently serve as President-elect of the Medical Association of Georgia.

I come before you today to share the story of how we are providing for the health of the low income uninsured in Hall County Georgia, especially children. We have a collaborative effort between private physicians, the Good News Clinic, the Hall County Health Department, the Health Access Initiative, and the Northeast Georgia Medical Center.

What I would like to convey to you is how the old model worked and explain the new model now operating in our community.

Good News Clinics (GNC) was founded in the early 1990's. It is the largest free clinic in the Southeast and one of the top 10 free clinics in the nation. Largely with volunteer physicians, they provide free medical and dental care including medications to low income, uninsured patients. This is accomplished through a free standing pharmacy staffed by a full-time pharmacist. In 2006 there were 8843 medical clinic patient visits, 7440 Dental Clinic visits and 66,451 pharmacy visits. The medications they provided for - all at no charge to the patient - had a retail value of $3.8 million. Hall County Georgia is located in Northeast Georgia and has a population of over 170,000.

The Hall County Health Department (HCHD) provides a prenatal program in conjunction with The Longstreet Clinic, a private multispecialty group. Prenatal care helps decrease infant mortality and infants' risk of health problems that would cost far more without prenatal intervention. In 2004, Hall County's infant mortality rate was 5.5 percent, compared to 8.5 percent for Georgia.

The Hall County Health Department also provides clinical services with 29,737 clients served in 2006.

In collaboration with community partners, Health Access Initiative (HAI) provides access to healthcare for uninsured patients. HAI is a consortium of partners including over 150 physicians, the local hospital, health department, free clinic, federally qualified clinic, United Way 2–1–1, Chamber of Commerce, and other partners. This group came together to primarily fill the need for specialty/surgical care for the uninsured/indigent.

HAI adds value to the existing resources in the community by providing specialty and surgical needs in a seamless manner. Under the old model, when someone needed surgery, the physician seeing the patient at the GNC or the HCHD would be in a predicament. The physician would have to stop what he or she was doing and take the time to make a number of phone calls in order to find a specialist/surgeon that would do a favor for the clinic. If surgery was indicated, the physician who was doing the clinic a favor would have to call an anesthesia friend and ask that physician to do a favor for him. If radiology was needed then the same would take place. Of course, the hospital/operating room would need to be contacted as well and this does not

Include the challenge if more than one specialty surgeon is needed. Under the old model it was a cumbersome time intensive process without structure, organization, or measurement.

HAI arose out the Hall County Medical Society. What is done under the new model is to bring all of the participants together in a more coordinated fashion. We have the physicians, hospital, x-ray, and labs all agree to provide the care for qualified patients on the front end. This way, when a patient is seen at the GNC that requires specialty care/surgery, the physician there makes the determination and writes the order. In this new model, HAI is notified and contacts the patient to make all the arrangements. A photo ID card is issued to the patient to identify them as an HAI patient using a customized software tracking program. If anesthesia is required for surgery, they are already committed to provide the care for HAI. The hospital is already on board to provide labs and OR as needed. Also, the Radiologist

is on board as well. The new model is seamless and user friendly. This also lifts the burden from the volunteer physician and allows the physician to see more patients.

To track this, the physician's office providing the care sends a health claim form over to HAI with the CPT code, the ICD9CM code, and the amount of services or care provided. We then enter this into our client tracking program so that we can track that the care was provided (i.e. the patient kept the appointment), as well as how much was provided. We make sure that the patient keeps all appointments and follow-up visits. Last year we documented a 90 percent compliance rate with patients keeping their appointments in the physician's offices. According to the code, we track the value of services provided. In 2006, HAI physicians provided over $815,000 in donated care.

The emergency room (ER) is another entry point into our system. Our ER in Hall County Ga is the third busiest in the State of Georgia with over 95,000 visits last year. When you think of an n ER, you think of trauma, MVA, or heart attack. However, the number one diagnosis in our ER is earache. The ER is used as a clinic. The cost of taking care of a patient in the ER as opposed to the office/clinic setting is three times. The GNC has data that shows their cost of care for a patient is $34 as compared to $221 for the same patient in the ER. The Andrew Young Health Policy Center at Georgia State University has similar data.

We have been too successful in getting people to go to the hospital/ER for care. The ERs have become clinics. At HAI, we work to keep the patient out of the ER. We want the patient to have a medical home that they use for their care. In fact, as part of our partnership, we are sent a daily report from the hospital notifying us if a patient in the HAI program was seen in the ER the day before. We then contact the patient to find out if the visit to the ER was the appropriate place to access the care that they needed. If not, then the patient is counseled on the appropriate or better way to obtain the care they need and we make sure they have a follow up appointment with their primary care provider if needed. We are trying to change the habits as well as the behavior as it relates to going to the ER.

Another important aspect to providing care and keeping healthcare resource utilization and cost down is to keep the patient from bouncing back and forth into the hospital. This requires the patient to have the medications needed available. If a patient does not obtain the medication required then they will have a difficult time improving and most likely will become worse with a more complicated illness that will be much more expensive and require much more in resources to treat. Through our partnership with GNC, HAI staffs a pharmacy tech to help provide free medications to meet acute needs. The medication assistance programs are used to meet chronic needs.

As you can see, it takes a lot of collaboration to make this work. The new model accomplishes this task. In fact, the HAI was honored by the Healthcare GA Foundation with the Community Service Collaborative of the Year Award for 2006.

In closing, I hope that you will recognize that individual communities can step up to the plate to provide for their citizens in need. I hope that you will continue to encourage and assist as possible, communities to start collaboratives like HAI and GNC. It really takes all parties coming together and working in a coordinated manner to provide for this problem.

This donated care model I have described is not THE answer to the problem of providing healthcare for those who are low income and uninsured, but it can be a PART of the answer and can go a long way in helping many people who could not otherwise obtain the healthcare they need.

Thank you again for allowing me to be here today. Thank you for the time, service and attention you are giving to this very important issue.

Mr. PALLONE. Thank you.

Ms. Koyanagi.

STATEMENT OF CHRIS KOYANAGI, POLICY DIRECTOR, BAZELON CENTER FOR MENTAL HEALTH LAW

Ms. KOYANAGI. Thank you, Mr. Chairman. I appreciate the opportunity to testify today on children's mental health.

I think for policy purposes, it is really helpful to think of children who need mental health services in some different groupings. First of all, one in five children in this country have a diagnosable men-

tal disorder that requires treatment. Eleven percent of children have a mental disorder that also is accompanied by a significant functional impairment. Obviously those children need more-intensive services. And 5 percent of children have a mental disorder which causes extreme functional impairment and those children need a wider array of services as well as more-intensive services.

And unfortunately for most children, access to mental health care is pretty abysmal. First of all, obviously children who are uninsured have little recourse, and what that is not the topic today, I do hope the committee will focus on the issue of uninsured children. But our public mental health systems are now so overburdened that they really cannot accept people who don't have either public insurance or private coverage.

But children who have private coverage through employer-based plans also have limits on their mental health services. Typically these plans only cover basic mental health, outpatient therapy, medications and hospitalization, and also there are limits on the array of those services, typically 30 inpatient days or 20 outpatient sessions is what you will find in most policies. Legislation introduced by Representatives Kennedy and Ramstad, the Mental Health Parity Act, would address this problem. We certainly urge the Congress to enact that bill.

But unfortunately, these limits in private plans have also been imported into SCHIP and Medicaid. SCHIP permits States to use benchmark plans, private plans as their models for SCHIP and many States do, and also now through the Deficit Reduction Act, Medicaid populations can also be placed into these kinds of benchmark plans which brings all these limits on mental health services into these public programs so many low-income children also cannot receive the course of mental health treatment that they need.

We would urge Congress to address this in SCHIP by requiring equity in the mental health benefits and also perhaps to either repeal the benchmark provision in Medicaid or at least require those benchmark plans include a reasonable mental health package.

In addition, SCHIP has a further problem for us in terms of mental health coverage because States may choose to cover only 75 percent of the actuarial value of the mental health benefit in the benchmark. So first your benchmark has limits and then under SCHIP, States can reduce even further and have even tighter limits. Chairman Dingell has introduced a bill, the Children's Health First Act, which would rectify that problem and we would urge the committee to take a look at that.

For children who have more severe mental health disorders, not only are the limits in the private plans and SCHIP inadequate but so is the range of services. These children require intensive community-based services such as in-home services, services in school. Their parents need help in understanding the disorder and how to respond when crises are emerging. These children need case management to meld these services together and various comprehensive programs, and a point of fact, we generally see that those services are only available under Medicaid.

The gaps in coverage can be disastrous for families. There are many families who are advised by public officials to give up custody of their child to a public agency in order to ensure that the child

has access to these kinds of comprehensive services. The GAO found almost 13,000 such children in just 19 State child welfare agencies and 30 county juvenile justice systems but GAO pointed out that these data grossly understate the problem because so few States keep the data.

So the bottom line is that Medicaid is the critical safety net for children with the most serious mental disorders and the only program that covers all the array of services that they need.

I would like to alert the committee that we are extremely concerned that the Medicaid community mental health services package is being amended by CMS, which is both having some audits conducted of these programs including I think an audit that is going on now in Georgia and also considering amending its regulations to reduce coverage of the community services. This is ironic because these community-based services are the least costly and because they enable children to stay with their own families or in alternative family-like settings, they are the most effective and the most likely to have long-lasting effects rather than placing children in institutions far away from their home.

The Surgeon General in 1999 and the President's Commission on Mental Health in 2003 have both made clear that we have now extremely effective treatments for mental health disorders but that these are far too frequently unavailable. America's children deserve a healthy start in life and that would include having early and effective access to treatment for their mental disorders.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Koyanagi follows:]

TESTIMONY OF CHRIS KOYANAGI

Good morning Chairman Pallone, Representative Deal and members of the Subcommittee. My name is Chris Koyanagi. I am the policy director for the Judge David L. Bazelon Center for Mental Health Law. The Bazelon Center is the leading national nonprofit, legal-advocacy organization representing people with mental disabilities. The Center works to define and uphold the rights of adults and children with mental disabilities who primarily rely on public services to ensure that they have equal access to health and mental health care, education, housing and employment.

Thank you for the opportunity to share our insights regarding mental health care for children in the public and private sector, including barriers to care, the consequences of inadequate access to care, and opportunities for Congress to improve access and provide a healthy start for children with mental health needs. It is our hope that this hearing will result in increased support for specific legislative proposals that will provide appropriate and timely access to mental health services and supports in both the public and private sectors.

During my testimony, I will describe opportunities within the committee's jurisdiction to address shortcomings in health care coverage for children with mental health needs such as approving the bipartisan Paul Wellstone Mental Health and Addiction Equity Act, enacting the bipartisan Keeping Families Together Act, eliminating the discriminatory limits on mental health care in State Children's Health Insurance Program (SCHIP), and preserving and strengthening the public sector Medicaid program.

OVERVIEW OF CHILDREN'S MENTAL HEALTH

Mental disorders affect about one in five American children and five to nine percent experience serious emotional disturbances that severely impair their functioning. Children from low-income households are at increased risk of mental health problems and research has indicated that children in Medicaid and SCHIP have a much higher prevalence of mental health problems than other insured children or even uninsured children. Tragically, a large majority of children struggling with

these mental disorders (79 percent by some estimates) do not receive the mental health services they need. Not surprisingly, uninsured children have a higher rate of unmet need than children with public or private insurance.

More than just a problem for the uninsured, children covered by private or public health plans have serious coverage gaps that prevent them from obtaining needed mental health services. For instance, private health plans set arbitrary limits on mental health coverage, such as caps on the number of times a child may be seen by a therapist over the course of a year. Approximately 68 percent of Americans under the age of 18 are covered by private insurance, while public programs (such as Medicaid and SCHIP) cover about 19 percent.

Within the public sector, discriminatory limits on mental health services in SCHIP that would not be permissible in Medicaid have restricted access to care for children and adolescents. Additionally, current Administrative activities that restrict reimbursement under the Medicaid rehabilitative services option limit access to a range of critical community-based services for children and adults that help them remain in the community—a goal supported by the President's Commission on Mental Health.

Without early and effective identification and intervention, childhood mental disorders can lead to a downward spiral of school failure, poor employment outcomes, and, later poverty in adulthood. Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are a much higher risk of suicide. According to the Surgeon General, an estimated 90 percent of children who commit suicide have a mental disorder.

Fortunately, poor outcomes for children with mental health needs can be prevented with access to appropriate services.

Insurance Reform Needed to Improve Access and Avoid Tragic Outcomes

Mental health treatment can be very expensive and most families rely upon insurance to help cover the cost of these services. For example, one outpatient therapy session can cost more than $100. Residential treatment facilities, which provide 24 hours of care, seven days a week, can cost $250,000 a year or more. However, employer based coverage often restricts access to mental health services for children and adults by placing limits on mental health coverage that they do not place on medical/surgical care. Limits on mental health coverage includes lower outpatient office visit limits, lower hospital stay limits, higher outpatient office visit co-payments, and higher outpatient office visit co-insurance. Data show that 94 percent of health maintenance plans and 96 percent of other plans have these restrictions. Families that face health insurance restrictions or exhaust their health insurance benefits are left without options.

Enacting mental health parity legislation (sponsored by Representatives Patrick Kennedy and Jim Ramstad) would be an essential first step to improving access in the private sector. Comprehensive parity legislation would help by prohibiting private insurers from denying access to needed services because of stigma and discrimination through current limitations and restrictions on mental health care that are not placed on general health care. Additionally, this Federal legislation would extend parity protections to the many self-funded employer-sponsored plans, that are currently exempt from any State mental health parity laws.

Gaps in services and limits in coverage can be disastrous and could lead to custody relinquishment whereby parents of children with mental disorders forgo custody of their children so they can become wards of the State and eligible for medical assistance. It is clear that across the country, children needing intensive mental health treatment are not receiving the care they need early on to prevent a host of adverse outcomes, including custody relinquishment. According to a General Accounting Office (GAO) report of April 2003, at least 12,700 children were placed in child welfare or juvenile justice system in 2001, solely to access State-funded mental health services. But this finding grossly understates the extent of the problem. GAO also found that most States and counties do not track how often custody relinquishment occurs and the 12,700 figure only reflects data from 19 child welfare departments and 30 county-level juvenile justice systems.

Legislation entitled the Keeping Families Together Act (H.R. 687–S. 382) has been introduced to help prevent parents from having to choose between custody and care by funding State-level interagency systems of care to improve mental health sources for children with mental disorders at risk of or already subjected to custody relinquishment. This legislation is sponsored by Representatives Patrick Kennedy, Jim Ramstad, and Pete Stark and Senators Susan Collins and Tom Harkin. It has been referred to the Energy and Commerce Committee and we urge the committee to approve this crucial piece of legislation as soon as possible.

Many families cite gaps in private insurance coverage as a major factor in their decisions to relinquish custody of their children. Private insurance plans do not cover the full array of intensive, community-based rehabilitative services that children with the most severe mental or emotional disorders need'services that would be covered under Medicaid.

MEDICAID PROVIDES VITAL ACCESS TO MENTAL HEALTH SERVICES

Medicaid is a critical source of support for mental health care, accounting for 20 percent of all mental health spending. Thanks in large part to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. Medicaid covers a comprehensive array of mental health services for children, including intensive services in the community that offer the greatest potential for avoiding costly institutional care. Medicaid is the only source of coverage that finances a full range of the rehabilitative services needed by children with mental disorders.

Last Congress, the bipartisan Family Opportunity Act was enacted as part of the Deficit Reduction Act to give States the option of allowing families with children with disabilities to buy Medicaid coverage for their children. This new law also created a demonstration program to provide home and community- based services to children with serious emotional and behavioral disorders as alternatives to psychiatric residential treatment. Enactment of these important provisions were a significant step in strengthening the Medicaid program by enabling families to meet their children's serious health and mental health needs while still keeping their families intact.

Further steps that must be taken include strengthening the Medicaid EPSDT benefit so that all children served by Medicaid, including those with mental health disorders, receive comprehensive screening. Non-compliance with EPSDT leads to reduced access to services and puts children in need of treatment at great risk of experiencing a host of other adverse consequences.

Medicaid coverage of community-based services through the rehabilitative services option is also critically important for children with mental health needs, especially children with serious disorders. These intensive rehabilitative community-based services for kids include multisystemic therapy, intensive home-based services for children and adolescents, therapeutic foster care, and behavioral aide services. These services are effective alternatives to institutional care for children and adults with severe mental disorders and are critical to promoting resiliency and recovery from mental illness. Medicaid is generally, the only source of coverage for them, specifically through the rehabilitative services option.

Unfortunately, the administration has indicated it will narrow coverage under the rehabilitative services option through regulatory changes. During the Deficit Reduction Act deliberations last Congress, Members deliberately rejected the administration's proposed changes to Medicaid coverage of rehabilitative services. Nonetheless, the administration is currently going forward with narrowing the scope of the rehabilitation option through the regulatory process as well as changes in coverage policy implemented through audits by the Health and Human Services Office of the Inspector General. The integrity of the Medicaid program and the standards set by Congress regarding the scope of optional service programs must be maintained. The back door approach being used by the administration, and shunned by Congress in the recent past, would drastically affect specific interventions that enable children and adults with serious mental disorders to function independently, learn in school, socialize age appropriately and experience symptom reduction.

SCHIP CHANGES REQUIRED TO ELIMINATE DISPARITIES AND IMPROVE ACCESS

SCHIP has generally been very successful in expanding health care coverage to millions of previously uninsured children, and States that simply expanded their Medicaid programs to cover these additional children offer comprehensive mental health services. However, States have the option to establish stand-alone SCHIP plans that are separate from their Medicaid programs and modeled after private insurance benchmark plans. Unfortunately, many States have adopted into these separate SCHIP plans private-insurance style limits on mental health services that would not be permissible in Medicaid, including caps on inpatient and outpatient care.

A study of SCHIP managed care plans found wide variations in the scope and limits of mental health treatment, with many States limiting outpatient services to 20 visits and inpatient days to 30 or less. These limits are not based on the medical needs of beneficiaries or best practice guidelines and result in coverage that is wholly inadequate for children with mental disorders. Another study found that children with complex mental health needs would have access to full coverage of needed serv-

ices in only approximately 40 percent of States due to limited benefits in SCHIP plans.

Mental health services are key components of the range of services children need for healthy development, and children enrolled in separate SCHIP plans deserve comprehensive coverage for their mental health needs For these children to have access to appropriate range of services, the law must be amended to ensure that all SCHIP plans provide mental health coverage that is equivalent to the coverage provided for general health care.

On February 28, 2007, over 40 national organizations representing children in the child welfare and mental health system sent a letter urging you to use this critical opportunity afforded by the SCHIP reauthorization process to prohibit disparate limits on mental health care for children in separate SCHIP plans.

Furthermore, language in the SCHIP statute even allows States to provide significantly less mental health coverage in their separate SCHIP plans than is covered in the benchmark plan they select. The law allows States that opt to create a separate plan to reduce the actuarial value of the mental health benefit by 25 percent—that is, the mental health benefit in SCHIP need only be actuarially equivalent to 75 percent of the benefit in the benchmark plan itself. This statutory provision authorizes States to establish SCHIP benefit packages that are totally inadequate for treating the great majority of childhood mental disorders.

This provision allowing the reduction of mental health benefits to 75 percent of the mental health benefits in the benchmark plans must be eliminated, and we commend Chairman Dingell for including a provision to do just that in his bill entitled the Children's Health First Act.

In conclusion, it is clear that many parents face tremendous barriers to accessing adequate mental health services for their children. Both the President's Commission on Mental Health and the Surgeon General have declared children's mental health coverage to be in crisis. It is unthinkable that a child with asthma would enter the child welfare system solely to access treatment. But, for children with mental health needs, this is precisely what does happen across the country.

I urge you to take advantage of all legislative opportunities to improve access to mental health services and supports for children. Proposals before the committee to remedy the failings of the private and public sector serving children with mental health needs must be seized to offer these children a fair chance at overcoming the extra challenges they face.

I thank you for holding this vital hearing and would be happy to answer any questions you might have.

Mr. PALLONE. Thank you very much, and I want to thank all the panelists and we will now have some questions. I recognize myself for 5 minutes for questions.

I am going to start with Dr. Krol. On the first panel, our ranking member, Congressman Deal, mentioned some technical changes to the Deficit Reduction Act which are needed to protect the children's benefit in Medicaid EPSDT, or Early Periodic Screening, Detection and Treatment, and then Mr. Scheppach described these changes as limiting flexibility, but my understanding is the technical change doesn't affect flexibility, it merely clarifies that this important children's benefit is unaffected. In fact, Senators Grassley and Baucus and Congressman Barton have acknowledged that the Deficit Reduction Act was not intended to affect the EPSDT benefit for children and I believe the American Academy of Pediatrics supports this technical change.

So I just wanted to ask you, Dr. Krol, why is EPSDT so important for children and why is this technical change needed to protect children's coverage, if you will?

Dr. KROL. Thank you for that question. First of all, the American Academy of Pediatrics does support that technical change wholeheartedly. I can speak as a pediatrician that takes care of kids and tell you a little bit of why EPSDT is so important to me and the children that I take care of, and I sometimes cringe when I hear

the acronym rather than saying it all out because we lose what it actually means when we just say EPSDT. It makes it a little easier on us. But the first part is early. What it allows me to do is, I can assess children as early as possible. When they walk into my door—well, they are not walking in the door at a week of age but they are brought into my door and I see these parents and I can assess risk in this child for a variety of different things and it gives me the opportunity to connect with my colleagues or my mental health colleagues if I need a referral. That is the first part. The periodicity is very important. Over time kids change, their circumstances change and the science changes over time, and I need that ability to over time assess a child. That relationship between me and that family is extremely important and EPSDT allows me to do that. But what it really allows me to do is to screen. It allows me to provide age-appropriate screening, trying to prevent disease before it happens rather than waiting until the disease comes and treating the disease. My goal is to have a child go 18 years through my office, 21 years through my office, sometimes 24 years through my office, and all I am doing is telling parents what is coming up, here is what is going to happen with your child, here is what is going to be going on rather than a child coming in and having some sort of issue that I am going to have to deal with as far as an illness. What EPSDT allows me to do is to prevent disease, ameliorate needs, address concerns of families and children, especially when they are adolescents, and it allows me to collaborate to address the disease if they do have that. I think that technical change is needed to maintain that.

Mr. PALLONE. Do you want to explain that a little more though, the technical change? What is it going to do?

Dr. KROL. Well, what I think it will do is, it will allow me to do these, all of these things that I think are required to help me take care of kids in a better way, to help them live healthy and happy lives. By taking away these benefits, by removing these benefits, we just can't do the job that we are doing right now.

Mr. PALLONE. OK. Let me also ask you, you mentioned obesity in your statement and I mentioned it in my opening statement and most people are aware the rates of childhood obesity are rapidly increasing. Can you comment on the impact that that trend is having on children and maybe on steps that pediatricians could take to combat the epidemic and also what types of things you think Congress could do to address the childhood obesity problem?

Dr. KROL. It is a significant epidemic and a difficult question to answer for a variety of reasons, not the least of which is so many things impact obesity. The simplest way to look at it is calories in versus calories out, and if you want to affect obesity, you affect one or the other and ideally both. So on the front end, working with families and children on what they are taking in as far as what kind of foods are healthy, amounts, portion size, not sucking down a two-liter bottle of your favorite soft drink or sugared substance, and just to bring up the sugared substances, they are common risk factors to obesity and oral health issues, so there is an opportunity there to make a difference, not only in obesity but also in oral health. On the other side of the equation, affecting the calories that are expended, getting children more active, helping families work

with kids because the reality is, if I am going to make a change in a child, it has to happen within the family. If I tell a family or if I tell a child you got to eat better, you got to exercise more, but the environment they live in, they have food instability where they are not quite sure where their next meal is going to be coming from and they are buying from their favorite fast-food restaurant because of 99-cent meals or they live in a neighborhood where they can't access physical activity or they go to a school that has removed physical activity, physical education from the program or they have a school lunch which they may qualify for a free school lunch but junk-food machines are open at the same time and they take their money and they spend in a junk-food machine rather than in the healthier lunches. I think there are a lot of barriers that we have to address. Some of these I can do in my office but some of these have to happen on a community level that I can help impact but it really takes a team to address those issues.

Mr. PALLONE. Thank you. Since my children left, I can say that they are still even today trying to go to McDonald's whenever possible and I have to constantly tell them that there are alternatives to McDonald's when we go out to eat.

Dr. KROL. There are.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman. With regard to clarifying the question that came up in the earlier panel and your question now with regard to the language that was in the Deficit Reduction Act about the flexibility and the benchmark plans of the States we have heard from the representative of the Governors' office, I would like to ask permission to insert in the record letters from Dr. McClellan and Secretary Leavitt indicating that they would never approve a State plan that did not include the EPSDT provision, and if that needs further clarification to satisfy provider groups or the Governors, maybe you and I should have a meeting with Secretary Leavitt or perhaps even a hearing in the subcommittee. So I think that is a clarification.

With regard to that issue of State benchmarks though, I know that one of our witnesses said they don't like those but the reality is that a State benchmark says that your plan has to include, first of all, the EPSDT screening provisions but it also has to be modeled by what you provide to your State employees and the most prominent private health insurance plan in your State. Now, what taxpayers are objecting to is that in almost every instance we find that the Government programs, whether it be Medicaid or whether it be SCHIP, provide better benefits than the average taxpayer who is paying for those are able to buy in their own plans. Now, that is the consideration, and if you are not aware of that consideration, then you are not hearing what the public is saying on these issues.

Let me address my remarks to Dr. Chapman, and Mr. Chairman, he is not only a doctor, he is a doctor two times over. He came to our community as an optometrist, practiced as an optometrist for a number of years, decided he wanted to take the next step up, went back to medical school and now came back and he is an ophthalmologist, a medical doctor and the president-elect of our State

medical association, so he is indeed a fine member of our community.

Let me draw some contrast though as to what we have heard in this hearing today. First of all, we heard in the first panel about the limitations on dental care, limitations that dealt with the available number of dentists out there, the reimbursement rates that are perhaps not what they should be, the number of dentists available in community health centers, et cetera. We have heard from Dr. Krol, who is saying that pediatricians need more money, that the plans don't pay enough. Children of course are perhaps the most mandated covered population group that we have in our country by virtue of all the Government programs that are out there. But let me contrast that with what Dr. Chapman is talking about. He is talking about in my community, which I am very proud and I appreciate him coming here to talk about it. My community, what happened to Diamonte Driver would never have happened in my community because it wasn't a question of whether or not he was Medicaid-eligible. It wasn't a question of whether he was SCHIP-eligible. He is talking about providing health care, dental and health care, without cost, without Government programs, without anything other than a medical and dental community and a community as a whole that is interested in providing these kinds of services. Now, there are impediments, first of all, with regard to the Hall County Health Access.

Now, Dr. Chapman, if I am correct, this is what, in collaboration with the medical community and the hospital, you are attempting to provide people who come in and don't have a medical home, don't know where to go other than the emergency room, a way of getting them appointments with doctors, including specialists. Is that correct?

Dr. CHAPMAN. That is correct. The problem that a lot of the clinics have when they come, they get a few doctors that are really interested in going and providing the care, then they get in there with a patient and then the patient needs a gallbladder surgery or needs some kind of other extra care. They look around, there is nobody there. Now when they turn around, we have somebody there.

Mr. DEAL. Of those 150 physicians, I believe you have every specialty covered except maybe one. Is that right?

Dr. CHAPMAN. Yes, sir, we have them all covered.

Mr. DEAL. All right. You have them all covered. And then you mentioned the component of Good News Clinics. Now this once again is a totally free clinic. Is that correct?

Dr. CHAPMAN. It is totally free. That is correct.

Mr. DEAL. And it is staffed by both active physicians and active dentists as well as retired physicians and retired dentists make up their service providers. Is that correct?

Dr. CHAPMAN. That is correct.

Mr. DEAL. They don't receive any Federal money?

Dr. CHAPMAN. No Federal money.

Mr. DEAL. No State money?

Dr. CHAPMAN. No State money.

Mr. DEAL. They have community chest and local voluntary charities that provide support, churches, et cetera.

Now, with regard to the first one, the Health Access where you have doctors who are willing to give their time free of charge, if you wanted to make a $10,000 contribution to that Health Access, you could write that off as a deduction, couldn't you?

Dr. CHAPMAN. That is correct.

Mr. DEAL. Can you write off your services that you provide free of charge in any form or fashion?

Dr. CHAPMAN. No, I cannot.

Mr. DEAL. Do you still have to provide malpractice insurance if you want to be covered?

Dr. CHAPMAN. I do.

Mr. DEAL. And the retired doctors and dentists in the Good News Clinic, they can't write off anything for their services, can they?

Dr. CHAPMAN. No, they cannot.

Mr. DEAL. And if they want liability protection, they have to pay for it out of their pocket. Is that right?

Dr. CHAPMAN. That is correct.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. PALLONE. Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

Dr. Krol, I want to make sure I have time to ask you a question further to explain about well-child visits and the importance of a medical home or primary provider. I am very interested in that.

But I want to start, Ms. Koyanagi, with you to speak about community-based services which is also dear to my heart. I want to clarify something for the record. On the values of mental health coverage and private plans as compared to SCHIP, it is my understanding that Congress required when SCHIP was passed in 1997 to provide coverage equaling 75 percent of the value of mental health coverage offered in private plans that were used as the, quote, benchmark. Is that correct?

Ms. KOYANAGI. That is correct.

Mrs. CAPPS. I want to make sure that is on the record. You talked about home- and community-based service for children with emotional and behavioral disorders. As one who spent a career in a school setting where a lot of this first comes to light and families are identified through the IEP process or screening process, the role of the endangered professional that I represent, which is a school nurse, that there are roles that are played there at that kind of place where all children come that then can be seen as part of the early diagnosis or assessment or picking up these kind of things to refer and also then some about the wraparound services that could be available to support a family with a mental health issue in a child.

Ms. KOYANAGI. That is correct. Schools in fact provide a significant amount of the mental health services that children receive and many children only receive mental health services through schools. So they are a very integral part of a community mental health network.

Mrs. CAPPS. And are there ways that we can in Congress ensure that this continues or that we build the strength of one community-based and include the school base include the community base?

Ms. KOYANAGI. Well, there are many ways, yes. The integration of mental health services with school-based services is one way

that the Substance Abuse and Mental Health Services Administration promotes. Medicaid could pay more effectively for school-based health services and mental health services. There are barriers there that could be eliminated that would make it easier for these services to be paid for within the schools.

Mrs. CAPPS. And we could provide some incentives for that happening here in Congress because some of those barriers are Federal. Am I right?

Ms. KOYANAGI. Absolutely.

Mrs. CAPPS. I know firsthand that when we can see the school and the community together as part of a referral and also a treatment facility, that I think it is a win-win. Am I correct?

Ms. KOYANAGI. Yes, that is correct.

Mrs. CAPPS. Thank you.

Dr. Krol, I also agree very much with your emphasis on the importance of regular well-child visits and the importance of a medical home or a health provider where multidisciplinary services could be centered. Can you explain about that? Should we have, for example, mental health services as a part of early periodic screening service and should mental health professionals be part of the medical home?

Dr. KROL. There is no question that mental health should be a part of that. Just as we mentioned the mouth is part of the body, the brain is a part of the body as well. There is no way around that. And in fact, development and mental health issues in younger children is extremely important. I can tell you in my own community in Toledo, Ohio, we have been talking considerably about the issue of autism and about trying to find ways to get to kids earlier in life to help families deal with this, which for many families is an overwhelming diagnosis anywhere on that spectrum and trying to find ways to include that within our medical home, within the services that we provide as a pediatrician but also making the connection out into the community because we cannot do it all in our office. We have to depend on our colleagues in the community as well as in the school, and I think what you pointed out is a significant barrier sometimes to many communities is the connection to mental health services. So you are exactly right. Mental health should be a significant part of the medical home.

Mrs. CAPPS. Some of the symptoms, speaking of autism, come about with the early toddler care programs, Head Start programs. It is when parents become aware that there is something that needs to be looked into further.

Dr. KROL. You are exactly right, and in my office I depend a lot on what parents tell me. When a parent tells me that something is wrong with their child, I take that very seriously and I pursue that to the point where I feel comfortable and the family feels comfortable that there either is or isn't something wrong with their child and so making that a significant and important part of the services that EPSDT provides and the services that I provide as a pediatrician in a medical home are very important.

Mrs. CAPPS. Thank you both very much. I yield back.

Mr. PALLONE. Thank you.

Dr. Burgess.

Mr. BURGESS. Thank you again, Mr. Chairman.

Dr. Krol, let me ask you, if I could, about the issue of medical devices in regard to children. Of course, adult populations' medical devices have achieved a good deal of success but as the late Dr. Benji Brooks down in Houston where I trained in medical school, the patron saint of pediatric surgery, used to drill on us in medical school that kids are different. They are not just little people. So as far as medical devices are concerned, we talk about things like shunts, stents and pacemakers and that sort of thing. They have to be designed specifically for children. Is that correct?

Dr. KROL. That is entirely correct, and while I am a general pediatrician, I depend significantly upon my surgical colleagues and they bring that to me all the time, the issues that they face regarding trying to adapt adult devices to kids if they can possibly do that, and the fact is that you can't. They aren't little adults.

Mr. BURGESS. Well, has the American Academy of Pediatrics conducted a study to determine if there is an unmet need for pediatric devices and what that unmet need might be?

Dr. KROL. I have to admit that I don't know for sure but I can definitely provide you with that information for your office. My thought is that we were looking into that considerably. We have surgical members of our academy that address these issues and face these issues all the time so I would not be surprised if our academy has addressed that but I don't know the specific policy that we have on it.

Mr. BURGESS. If you find it and you can make it available to the committee, that would be super.

We of course hear a lot on this committee about things like health literacy, low health literacy, health disparities. So what steps can be taken to coordinate care and ensure that children or in this case the children's parents actually follow up and take the physician's advice and follow up on the care recommended by the physician and do their appropriate follow-up visits?

Dr. KROL. Well, you pointed out one of the many significant barriers to quality health care for children is the communication that we have with the parents specifically and a lot of that has to do with the literacy level, not just health literacy but literacy in general. So trying to find ways to make information and some of this very technological information that is easy for me to talk with you about as physicians but to bring that to a level where a family can understand that and a family that may have a fifth-grade, sixth-grade, eighth-grade reading level is sometimes very difficult. So trying to find ways to make information available to these families in a way that they can digest it, understand it, feel informed about it, able to make competent decisions for their kids is extremely important. So finding any way where we can do that, we work very hard on trying to do that, not only on a health literacy level but also on a language level with families that speak different languages that come into our communities. It is a significant barrier to health care and also a significant barrier to quality. Making sure that what I am saying is what the family is hearing is very important.

Mr. BURGESS. And along the same lines of the medical devices, if you have information that any study that the American Academy of Pediatrics has done regarding levels of health literacy and levels

of compliance, again I think the committee would be interested in that.

In your testimony, you say that dollar for dollar, providing better health care for children represents one of the best returns on investment available and obviously we do have to be concerned about return on investment when we are talking about the taxpayer's dollar. So in a program like SCHIP, for example, that was specifically designed for children, has children as one of the capital letters in the acronym, would it not make sense to focus on providing care to children rather than providing care to adults in the SCHIP program?

Dr. KROL. I can say this: As a pediatrician, taking care of a child is not just about taking care of the child. It is about taking care of the family that is taking care of that child. It is about an interaction and a relationship with the family. We can't pull the child away from that family and take care of them individually. When they leave my office, they go back to a home environment and go back to family members, siblings, aunts and uncles, grandmas and grandpas. We have to approach child health in some ways as family health, and as far as a specific benefit for parents, I will say that we can't ignore the fact that children live in families and they can't survive on their own without families, and the care that I provide includes care for families and not just children.

Mr. BURGESS. But again, as a dollar for dollar return on investment, a dollar invested in a child's health is going to go farther than a dollar invested in an adult's health. Is that a fair statement?

Dr. KROL. I would say that yes, the money that is spent on children is definitely a great investment. I can't say that it is necessarily better or worse.

Mr. BURGESS. Well, if we need to develop other programs to take care of family members who are not children, I mean, it seems to go beyond the scope of the SCHIP program.

Mr. Chairman, I am going to yield back but I do want to make one general commercial announcement. We are going to have our trauma bill up on the floor later today, and of course, as a shameless tie-in to the issue that is before us today, the leading cause of death for children over the age of 1-year is injury, specifically motor vehicle crashes, firearms and drownings, so our trauma bill that we are going to have on the floor today is extremely important and germane to this discussion.

I will yield back.

Mr. PALLONE. Thank you. It is not a commercial announcement though, but thank you.

That concludes our questions. I want to thank all of you for being here today and for bearing with us as we ask questions.

I would just remind Members that you may submit additional questions for the record to be answered by the relevant witnesses and the questions should be submitted to the committee clerk within the next 10 days. The clerk will notify your offices of the procedure so obviously we may give you additional written questions and I hope you bear with us.

Thank you very much, and without objection, this meeting of the subcommittee is adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]
[Material submitted for inclusion in the record follows:]

STENY H. HOYER
MAJORITY LEADER
5TH DISTRICT, MARYLAND

Congress of the United States
House of Representatives
Washington, DC 20515–6502

STATEMENT OF CONGRESSMAN STENY H. HOYER
House Majority Leader
Before the Energy and Commerce Subcommittee on Health
March 27, 2007

Chairman Dingell, Subcommittee Chairman Pallone, Ranking Member Barton and Ranking Member Deal, and Members of the Subcommittee:

I want to thank you for calling this important hearing in such a speedy manner.

Last February, I was greatly saddened and appalled to hear of the tragic and preventable death of 12-year-old Deamonte Driver of Prince George's County, Maryland. Deamonte died from a brain infection brought on by an abscessed tooth, which could have been easily treated with a routine tooth extraction.

Unfortunately for Deamonte's family, like too many other low-income families, dental care is out of their reach. Coverage under Medicaid's State Children's Health Insurance Program (SCHIP) varies from state to state, and even in states that provide dental services, such as in Maryland, too few dentists participate because of low reimbursement rates. As a result, less than one in three children enrolled in Maryland's Medicaid program receive dental care, and only 900 of the state's 5,500 dentists accept Medicaid.

It is shocking that in the U.S. today, oral disease is the most prevalent chronic disease of children, and 80 percent of dental decay occurs in 25 percent of children, primarily low-income and minority children. Not surprisingly dental care tops parents' list of health care concerns.

MAJORITY LEADER OFFICE:
H-107, THE CAPITOL
WASHINGTON, DC 20515
(202) 225-3130
(202) 226-0663 (FAX)
http://majorityleader.house.gov

WASHINGTON, DC OFFICE:
1705 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-4131
(202) 225-4300 (FAX)
http://www.hoyer.house.gov

GREENBELT DISTRICT OFFICE:
U.S. DISTRICT COURT HOUSE
6500 CHERRYWOOD LANE, SUITE 310
GREENBELT, MD 20770
(301) 474-0119
(301) 474-4697 (FAX)

WALDORF DISTRICT OFFICE:
401 POST OFFICE ROAD, #202
WALDORF, MD 20602
(301) 843-1577
(301) 843-1331 (FAX)

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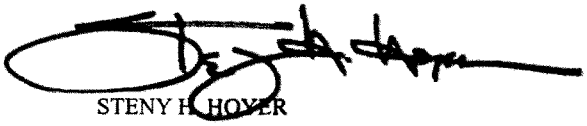
No child should die from a treatable toothache, and I am outraged by this tragedy.

That is why I recently joined my fellow Congressional delegates from Maryland in calling for comprehensive dental benefits under SCHIP. And I commend this Subcommittee for highlighting this grave situation.

As Congress takes up the reauthorization of SCHIP, I look forward to working with Chairman Dingell and the members of this committee to ensure that all eligible children are enrolled and receive adequate health care. That includes providing children with the preventative dental care and access to providers that they need.

Thank you for your attention,



STENY H. HOYER

COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

ERNIE FLETCHER
GOVERNOR

700 CAPITAL AVENUE
SUITE 100
FRANKFORT, KY 40601
(502) 564-2611
FAX: (502) 564-2517

March 15, 2007

Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Members of the House Energy and Commerce Committee:

In May 2006, Kentucky was granted approval to implement major reforms in our Medicaid program. The majority of the changes Kentucky implemented were through flexibilities granted under the Deficit Reduction Act of 2006 (DRA). The ability to offer four distinct benefit packages to meet the individual needs of our members was a welcomed opportunity. The Deficit Reduction Act of 2006 was a positive step allowing states the much needed flexibility to curtail exorbitant cost increases and to generally improve their Medicaid programs.

The supplemental emergency spending bill currently under consideration appears to contain language that may impact a state's ability to provide benchmark packages to its Medicaid members. While I understand the importance of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program and believe in it wholeheartedly, I feel the language intended as technical corrections to Section 6044 of the DRA should be placed in a more appropriate bill where the true intent cannot be misconstrued or misinterpreted. In addition, I believe all states should have the opportunity to review the language and submit testimony regarding the fiscal impact this alteration will have on their programs before the bill is passed.

While I believe the proposed change will have little impact on Kentucky's program if implemented, I am concerned that the provision may adversely impact other states, such as those experiencing a budget shortfall in their Children's Health Insurance Program (CHIP) this year. Therefore, I respectfully request that the language intended for Section 6003 of the DRA be moved to a bill that would be more appropriate and suitable for its intent and that states be given the opportunity to review and discuss any financial needs resulting from the proposed alteration of the DRA.

Sincerely,

Ernie Fletcher

washingtonpost.com

http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116_pf.html

For Want of a Dentist

Pr. George's Boy Dies After Bacteria From Tooth Spread to Brain

By Mary Otto
Washington Post Staff Writer
Wednesday, February 28, 2007; B01

Twelve-year-old Deamonte Driver died of a toothache Sunday.

A routine, $80 tooth extraction might have saved him.

If his mother had been insured.

If his family had not lost its Medicaid.

If Medicaid dentists weren't so hard to find.

If his mother hadn't been focused on getting a dentist for his brother, who had six rotted teeth.

By the time Deamonte's own aching tooth got any attention, the bacteria from the abscess had spread to his brain, doctors said. After two operations and more than six weeks of hospital care, the Prince George's County boy died.

Deamonte's death and the ultimate cost of his care, which could total more than $250,000, underscore an often-overlooked concern in the debate over universal health coverage: dental care.

Some poor children have no dental coverage at all. Others travel three hours to find a dentist willing to take Medicaid patients and accept the incumbent

paperwork. And some, including Deamonte's brother, get in for a tooth cleaning but have trouble securing an oral surgeon to fix deeper problems.

In spite of efforts to change the system, fewer than one in three children in Maryland's Medicaid program received any dental service at all in 2005, the latest year for which figures are available from the federal Centers for Medicare and Medicaid Services.

The figures were worse elsewhere in the region. In the District, 29.3 percent got treatment, and in Virginia, 24.3 percent were treated, although all three jurisdictions say they have done a better job reaching children in recent years.

"I certainly hope the state agencies responsible for making sure these children have dental care take note so that Deamonte didn't die in vain," said Laurie Norris, a lawyer for the Baltimore-based Public Justice Center who tried to help the Driver family. "They know there is a problem, and they have not devoted adequate resources to solving it."

Maryland officials emphasize that the delivery of basic care has improved greatly since 1997, when the state instituted a managed care program, and 1998, when legislation that provided more money and set standards for access to dental care for poor children was enacted.

About 900 of the state's 5,500 dentists accept Medicaid patients, said Arthur Fridley, last year's president of the Maryland State Dental Association. Referring patients to specialists can be particularly difficult.

Fewer than 16 percent of Maryland's Medicaid children received restorative services -- such as filling cavities -- in 2005, the most recent year for which figures are available.

For families such as the Drivers, the systemic problems are often compounded by personal obstacles: lack of transportation, bouts of homelessness and erratic telephone and mail service.

The Driver children have never received routine dental attention, said their mother, Alyce Driver. The bakery, construction and home health-care jobs she has held have not provided insurance. The children's Medicaid coverage had temporarily lapsed at the time Deamonte was hospitalized. And even with Medicaid's promise of dental care, the problem, she said, was finding it.

When Deamonte got sick, his mother had not realized that his tooth had been bothering him. Instead, she was focusing on his younger brother, 10-year-old DaShawn, who "complains about his teeth all the time," she said.

DaShawn saw a dentist a couple of years ago, but the dentist discontinued the treatments, she said, after the boy squirmed too much in the chair. Then the family went through a crisis and spent some time in an Adelphi homeless shelter. From there, three of Driver's sons went to stay with their grandparents in a two-bedroom mobile home in Clinton.

By September, several of DaShawn's teeth had become abscessed. Driver began making calls about the boy's coverage but grew frustrated. She turned to Norris, who was working with homeless families in Prince George's.

Norris and her staff also ran into barriers: They said they made more than two dozen calls before reaching an official at the Driver family's Medicaid provider and a state supervising nurse who helped them find a dentist.

On Oct. 5, DaShawn saw Arthur Fridley, who cleaned the boy's teeth, took an X-ray and referred him to an oral surgeon. But the surgeon could not see him until Nov. 21, and that would be only for a consultation. Driver said she learned that

DaShawn would need six teeth extracted and made an appointment for the earliest date available: Jan. 16.

But she had to cancel after learning Jan. 8 that the children had lost their Medicaid coverage a month earlier. She suspects that the paperwork to confirm their eligibility was mailed to the shelter in Adelphi, where they no longer live.

It was on Jan. 11 that Deamonte came home from school complaining of a headache. At Southern Maryland Hospital Center, his mother said, he got medicine for a headache, sinusitis and a dental abscess. But the next day, he was much sicker.

Eventually, he was rushed to Children's Hospital, where he underwent emergency brain surgery. He began to have seizures and had a second operation. The problem tooth was extracted.

After more than two weeks of care at Children's Hospital, the Clinton seventh-grader began undergoing six weeks of additional medical treatment as well as physical and occupational therapy at another hospital. He seemed to be mending slowly, doing math problems and enjoying visits with his brothers and teachers from his school, the Foundation School in Largo.

On Saturday, their last day together, Deamonte refused to eat but otherwise appeared happy, his mother said. They played cards and watched a show on television, lying together in his hospital bed. But after she left him that evening, he called her.

"Make sure you pray before you go to sleep," he told her.

The next morning at about 6, she got another call, this time from the boy's grandmother. Deamonte was unresponsive. She rushed back to the hospital.

"When I got there, my baby was gone," recounted his mother.

She said doctors are still not sure what happened to her son. His death certificate listed two conditions associated with brain infections: "meningoencephalitis" and "subdural empyema."

In spite of such modern innovations as the fluoridation of drinking water, tooth decay is still the single most common childhood disease nationwide, five times as common as asthma, experts say. Poor children are more than twice as likely to have cavities as their more affluent peers, research shows, but far less likely to get treatment.

Serious and costly medical consequences are "not uncommon," said Norman Tinanoff, chief of pediatric dentistry at the University of Maryland Dental School in Baltimore. For instance, Deamonte's bill for two weeks at Children's alone was expected to be between $200,000 and $250,000.

The federal government requires states to provide oral health services to children through Medicaid programs, but the shortage of dentists who will treat indigent patients remains a major barrier to care, according to the National Conference of State Legislatures.

Access is worst in rural areas, where some families travel hours for dental care, Tinanoff said. In the Maryland General Assembly this year, lawmakers are considering a bill that would set aside $2 million a year for the next three years to expand public clinics where dental care remains a rarity for the poor.

Providing such access, Tinanoff and others said, eventually pays for itself, sparing children the pain and expense of a medical crisis.

Reimbursement rates for dentists remain low nationally, although Maryland, Virginia and the District have increased their rates in recent years.

Dentists also cite administrative frustrations dealing with the Medicaid bureaucracy and the difficulties of serving poor, often transient patients, a study by the state legislatures conference found.

"Whatever we've got is broke," Fridley said. "It has nothing to do with access to care for these children."

STATEMENT BY MARK B. MCCLELLAN, M.D., PH.D, ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Questions have been raised about the new section 1937 of the Social Security Act (SSA) (as added by the Deficit Reduction Act of 2005) that permits states to provide Medicaid benefits to children through benchmark coverage or benchmark equivalent coverage. If a State chooses to exercise this option, the specific issue has been raised as to whether children under 19 will still be entitled to receive EPSDT benefits in addition to the benefits provided by the benchmark coverage or benchmark equivalent coverage. The short answer is: children under 19 will receive EPSDT benefits.

After a careful review, including consultation with the Office of General Counsel, CMS has determined that children under 19 will still be entitled to receive EPSDT benefits if enrolled in benchmark coverage or benchmark equivalent coverage under the new section 1937. CMS will review each State plan amendment (SPA) submitted under the new section 1937 and will not approve any SPA that does not include the provision of EPSDT services for children under 19 as defined in section 1905(r) of the SSA.

In the case of children under the age of 19, new section 1937 (a) (1) is clear that a state may exercise the option to provide Medicaid benefits through enrollment in coverage that at a minimum has two parts. The first part of the coverage will be benchmark coverage or benchmark equivalent coverage, as required by subsection (a) (1) (A) (i), and the second part of the coverage will be wrap-around coverage of EPDST services as defined in section 1905(r) of the SSA, as required by subsection (a) (1) (A) (ii). A State cannot exercise the option under section 1937 with respect to children under 19 if EPSDT services are not included in the total coverage provided to such children.

Subparagraph (C) of section 1937 (a) (1) permits states to also add wrap-around or additional benefits. In the case of children under 19, wrap-around or additional benefits that a state could choose to provide under subparagraph (C) must be a benefit in addition to the benchmark coverage or benchmark equivalent coverage and the EPSDT services that the state is already required to provide under subparagraph (A) of that section. Subparagraph (C) does not in any way give a state the flexibility to fail to provide the EPSDT services required by subparagraph (A) (ii) of section 1937 (a) (1).

THE SECRETARY OF HEALTH AND HUMAN SERVICES

August 25, 2006

The Honorable Joseph Barton
Chairman
Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter regarding the Deficit Reduction Act of 2005 (DRA) and congressional intent with regard to sections 6041 and 6044 of the DRA.

Section 6041 of the DRA created a new section 1916A of the Social Security Act (the Act) in which States can choose alternative premiums and cost sharing for certain Medicaid beneficiaries. On June 16, 2006, we issued guidance to the States on cost sharing. As stated in that guidance, for persons with family income at or below 100 percent of the Federal poverty level, we plan to apply the limitations of section 1916 of the ACT so that States may not impose alternative premiums and cost sharing under section 1916A for this group.

Section 6044 of the DRA provides that States can choose to implement benefit flexibilities authorized by a newly created section 1937 of the Act. However, the statute prohibits States from requiring enrollment in an alternative benefit package for our most vulnerable populations; i.e., pregnant woman; certain low-income parents, adults, and children with disabilities; dual eligibles; certain other aged and disabled individuals in need of long-term care; and adults and children with special needs.

Regarding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, our guidance to States issued on March 31, 2006, makes it clear that States that choose to offer benchmark plans must provide EPSDT to all eligible children.

I look forward to working with you to improve health care for our most vulnerable populations and to implement these critical DRA provisions. Please call me if you

have further concerns or questions. I will also provide this response to the cosigner of your letter.

Sincerely,

Michael O. Leavitt
Secretary

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