

ONE YEAR LATER: MEDICAID'S RESPONSE TO SYSTEMIC PROBLEMS BY THE DEATH OF DEAMONTE DRIVER

HEARING

BEFORE THE
SUBCOMMITTEE ON DOMESTIC POLICY
OF THE
COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 14, 2008

Serial No. 110-164

Printed for the use of the Committee on Oversight and Government Reform



Available via the World Wide Web: <http://www.gpoaccess.gov/congress/index.html>
<http://www.oversight.house.gov>

U.S. GOVERNMENT PRINTING OFFICE

49-775 PDF

WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HENRY A. WAXMAN, California, *Chairman*

EDOLPHUS TOWNS, New York	TOM DAVIS, Virginia
PAUL E. KANJORSKI, Pennsylvania	DAN BURTON, Indiana
CAROLYN B. MALONEY, New York	CHRISTOPHER SHAYS, Connecticut
ELIJAH E. CUMMINGS, Maryland	JOHN M. McHUGH, New York
DENNIS J. KUCINICH, Ohio	JOHN L. MICA, Florida
DANNY K. DAVIS, Illinois	MARK E. SOUDER, Indiana
JOHN F. TIERNEY, Massachusetts	TODD RUSSELL PLATTS, Pennsylvania
WM. LACY CLAY, Missouri	CHRIS CANNON, Utah
DIANE E. WATSON, California	JOHN J. DUNCAN, JR., Tennessee
STEPHEN F. LYNCH, Massachusetts	MICHAEL R. TURNER, Ohio
BRIAN HIGGINS, New York	DARRELL E. ISSA, California
JOHN A. YARMUTH, Kentucky	KENNY MARCHANT, Texas
BRUCE L. BRALEY, Iowa	LYNN A. WESTMORELAND, Georgia
ELEANOR HOLMES NORTON, District of Columbia	PATRICK T. McHENRY, North Carolina
BETTY McCOLLUM, Minnesota	VIRGINIA FOXX, North Carolina
JIM COOPER, Tennessee	BRIAN P. BILBRAY, California
CHRIS VAN HOLLEN, Maryland	BILL SALI, Idaho
PAUL W. HODES, New Hampshire	JIM JORDAN, Ohio
CHRISTOPHER S. MURPHY, Connecticut	
JOHN P. SARBANES, Maryland	
PETER WELCH, Vermont	

PHIL SCHILIRO, *Chief of Staff*

PHIL BARNETT, *Staff Director*

EARLEY GREEN, *Chief Clerk*

DAVID MARIN, *Minority Staff Director*

SUBCOMMITTEE ON DOMESTIC POLICY

DENNIS J. KUCINICH, Ohio, *Chairman*

TOM LANTOS, California	DARRELL E. ISSA, California
ELIJAH E. CUMMINGS, Maryland	DAN BURTON, Indiana
DIANE E. WATSON, California	CHRISTOPHER SHAYS, Connecticut
CHRISTOPHER S. MURPHY, Connecticut	JOHN L. MICA, Florida
DANNY K. DAVIS, Illinois	MARK E. SOUDER, Indiana
JOHN F. TIERNEY, Massachusetts	CHRIS CANNON, Utah
BRIAN HIGGINS, New York	BRIAN P. BILBRAY, California
BRUCE L. BRALEY, Iowa	

JARON R. BOURKE, *Staff Director*

CONTENTS

	Page
Hearing held on February 14, 2008	1
Statement of:	
Smith, Dennis, director, Center for Medicaid and State Operations; Dr. Jim Crall, director, Oral Health Policy Center, professor and Chair, Section of Pediatric Dentistry; and Dr. Burton Edelstein, founding Chair, Children's Dental Health Project, professor and Chair, Social and Behavioral Sciences, Columbia University College of Dental Medicine	16
Crall, Dr. Jim	30
Edelstein, Dr. Burton	45
Smith, Dennis	16
Letters, statements, etc., submitted for the record by:	
Crall, Dr. Jim, director, Oral Health Policy Center, professor and Chair, Section of Pediatric Dentistry, prepared statement of	34
Cummings, Hon. Elijah E., a Representative in Congress from the State of Maryland, prepared statement of	100
Edelstein, Dr. Burton, founding Chair, Children's Dental Health Project, professor and Chair, Social and Behavioral Sciences, Columbia University College of Dental Medicine, prepared statement of	47
Kucinich, Hon. Dennis J., a Representative in Congress from the State of Ohio:	
Letter dated October 2, 2007	54
Prepared statement of	6
Various letters	60
Smith, Dennis, director, Center for Medicaid and State Operations, prepared statement of	19
Watson, Hon. Diane E., a Representative in Congress from the State of California, prepared statement of	28

ONE YEAR LATER: MEDICAID'S RESPONSE TO SYSTEMIC PROBLEMS BY THE DEATH OF DEAMONTE DRIVER

THURSDAY, FEBRUARY 14, 2008

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

The subcommittee met, pursuant to notice, at 3:15 p.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Watson, Issa, and Shays.

Staff present: Noura Erakat, counsel; Jean Gosa, clerk; Emily Jagger, intern; and Vic Edgerton, legislative director, Office of Congressman Dennis J. Kucinich.

Mr. KUCINICH. The subcommittee will come to order.

Just for the attention of those who are in the audience and those who are here to testify, the House is in session right now. We have a series of votes. There has been a brief interruption for a motion of personal privilege. That discussion could go on for a while.

So in the interest of expediting this hearing and respecting the schedules of the witnesses, I have come here to start the hearing. At some point my colleague, Mr. Issa, will join us. I want to proceed right now, though, given the hour and the fact that the House will be finished when it completes this series of votes. I just want to make sure that we respect your time.

This is the Domestic Policy Subcommittee of the Oversight and Government Reform Committee, a hearing on Reform of Dental Care in Medicaid.

[Slide shown.]

Mr. KUCINICH. One year ago, a 12-year-old boy, Deamonte Driver, died of a brain infection caused by an untreated tooth decay. Deamonte lived in Prince George's County, Maryland, and was eligible for Medicaid, but he hadn't seen a dentist in more than 4 years.

In May 2007, my subcommittee held a hearing to examine the circumstances that led to Deamonte's preventable death. Today we will examine what corrective actions the Center for Medicaid and State Operations [CMS], has taken since Deamonte's death to reform the pediatric dental program for Medicaid-eligible children.

During our hearing last May, we learned that Deamonte's mother, Alyce Driver, tried to obtain oral health services for her son and

his brothers. But there was a problem: there were no dentists available for her Medicaid-eligible children enrolled by United HealthCare Co. [United]. According to Laurie Norris, the Driver family lawyer and a witness at last year's hearing, "it took one mother, one lawyer, one help line supervisor, and three case management professionals to make a dental appointment for one Medicaid child."

After the hearing, I instructed my subcommittee staff to investigate the adequacy of the dental provider network available to Medicaid-eligible children enrolled in the same managed care company that was responsible for Deamonte.

My subcommittee investigated United's dental network and records of claims submitted for services rendered to United beneficiary children in 2006. Our staff found that Deamonte was far from the only child in Maryland who hadn't seen a dentist in 4 or more consecutive years. In fact, nearly 11,000 Maryland children enrolled in United had not seen a dentist in four or more consecutive years, putting them in the same precarious position that Deamonte was at the time of his death.

The investigation also revealed that United's dental provider network was not nearly as robust as they had claimed. We discovered that 55 percent of all dental services rendered in 2006 in the county where Deamonte resided were conducted by only seven dentists. We also discovered that 19 of the dentists listed in the dental provider network in the county provided zero services to Medicaid-eligible children in 2006.

United has concurred with all of the subcommittee's findings and they are cooperating with the subcommittee's broader investigation as well.

There is no dispute that Federal law, specifically Section 1902 of the Social Security Act, mandates that Medicaid-eligible children are entitled to routine dental services and any necessary treatment on a periodic basis. Why, then, were there no dentists available to deliver that care to Deamonte? More importantly, why didn't CMS, the Federal agency responsible for administering Medicaid, do something about it?

At our hearing last May, we asked Mr. Dennis Smith, the Director of CMS, that question. We asked him why he did not take any action in Maryland after he learned that only 24 percent of its children got any dental care in 2004, and he responded. And I think some of you are familiar with the quotes, but here they are.

[Slide shown.]

Mr. KUCINICH. "The enforcement tools . . . are to sanction the State financially. . . . I have not sanctioned States for the access issue in dental care."

[Slide shown.]

Mr. KUCINICH. He went on to say: "Enforcement is about taking financial penalties against states."

But financial sanctions are absolutely not the only enforcement tools available to CMS. The Director of CMS has many enforcement tools available to him, and in a May 17, 2007 letter that Congressman Cummings of Maryland and I sent to Mr. Smith, we enumerated just a few of them.

[Slide shown.]

Mr. KUCINICH. We suggested that CMS—and these are our suggestions: Conduct a critical incident review of Deamonte Driver's death; make children's access to dental care a CMS enforcement priority and communicate this priority to all States; establish a standard or goal for the percentage of eligible children to receive preventive dental services; improve current reporting requirements, namely, make the CMS 416 forms more reliable and accurate; identify the poorest performing States and assess why those States are performing poorly and suggest ways they can improve their performance; rank the States in order of performance vis-a-vis the provision of dental care; ensure that administrators of Medicaid programs have ready access to the policy guidance they need in order to cover children's dental services with respect to reimbursement rates and managed care oversight; issue a letter to State Medicaid directors reminding them of their legal obligations and ask them to submit plans of action for ensuring that children will have adequate access to dental services; assess civil money penalties against any managed care organization that has contracted with a Medicaid agency and has failed to do so.

What a difference a year makes. Since our hearing, Medicaid has indeed used several tools to enforce Federal law. We will learn about some of these actions today.

But time doesn't heal all wounds. In important ways, Medicaid still hasn't learned the most important lessons from the preventable death of Deamonte Driver.

According to experts, one of the most important things that CMS can do is address the issue of reimbursement rates at a national policy level.

In 2000, CMS contracted with the American Association of Pediatric Dentists [AAPD] to draft a Guide to Children's Dental Care in Medicaid. This contract stipulated that the Guide was to provide policy guidance to the State Medicaid agencies about implementing and managing Medicaid's Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] system.

[Slide shown.]

Mr. KUCINICH. The AAPD submitted the completed Guide to CMS in 2001. However, CMS did not publish it until 2004, and when it finally did publish it, under the authority and leadership of Mr. Smith, the entire policy section on reimbursement rates and managed care oversight was redacted.

[Slide shown.]

Mr. KUCINICH. Now, I don't understand why Mr. Smith would do that, when, at our hearing last year, he himself said, "The key to improving access principally from the provider perspective is to increase reimbursement rates."

Clearly, Mr. Smith understands the nature of the problem, as well as a cornerstone to its solution. Yet, as Director of CMS, we have not seen sufficient evidence that he would use his understanding to solve that problem or, at the very least, to improve it.

In our letter to him, Mr. Cummings and I urged Mr. Smith to revise the Guide and incorporate information relating to provider reimbursement and managed care oversight that was edited out of the 2004 version. Alternatively, we asked him to send a State Medicaid Director letter that provided this critical policy information.

[Slide shown.]

Mr. KUCINICH. We have not received cooperation on our request. Mr. Smith explained, in slide 7: “States have ready access to all Medicaid policy on reimbursement and managed care oversight through existing Federal publications and documents.” That answer that we received is not acceptable.

In Georgia, that information was available when its three managed care organizations cut their reimbursement rates and limited their dental services in 2006. That was a profit-boosting move on their part. In Maryland, that information was available when Deamonte died of a brain infection caused by untreated tooth decay.

In the District of Columbia, Virginia, and 20 other States, that information has been available as Small Smiles—an abusive, possibly criminal, multi-State dental provider—preys on Medicaid-eligible children to generate a profit. Because inadequate reimbursement rates are often insufficient to cover even an honest dentist’s costs, Small Smiles conceived of another way to make a profit: a predatory mill where multiple, sometimes unnecessary, procedures are imposed, assembly-line style, on children with little regard for their welfare or proper dental practice.

Small Smiles routinely barred parents from their children’s side during dental procedures, and in separate instances performed more than a dozen root canals on a child’s baby teeth, and, in Arizona, fatally overdosed a child with anesthesia. While CMS certainly doesn’t condone these unscrupulous and horrific practices, the silence on reimbursement rates creates economic incentives for these kind of practices to flourish.

CMS’s role as Federal administrator of Medicaid is not just to have information available, but to make sure that the States have and use that information and comply with Federal law.

Prior to Mr. Smith’s taking the reins at CMS, the former CMS director understood this concept and issued a State Medicaid Director letter requesting information on State efforts to ensure children’s access to dental services under Medicaid. The letter indicated that CMS would undertake intensive oversight of States whose dental utilization rates, as indicated on the CMS-416 annual reports, were below 30 percent, including site visits by regional office staff.

States with utilization rates between 30 and 50 percent would be subject to somewhat less stringent review. All States were asked to submit “Plans of Action” detailing how they would improve access to oral health care within 3 years. The letter not only sent a message to States that oral health was a Medicaid priority but, that as a provider of half of the States’ Medicaid budgets, CMS was monitoring their performance closely.

Significantly, Maryland was among the States with utilization rates below 30 percent. But between 2001, when Maryland submitted the information to CMS, and February 2007, when Deamonte died, CMS, under the leadership of Mr. Smith, hasn’t done anything to followup with these poorest performing States.

The new administration in Maryland under Governor O’Malley has laudably taken initiative since Deamonte Driver’s death. Maryland’s Medicaid Administration has taken a number of significant

actions. They did that on their own in light of all the local attention Deamonte's tragic death earned. But what has CMS done nationally, in other States besides Maryland, to prevent the situation that led to Deamonte's death? Today we are going to find out.

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

**Opening Statement
Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee
Hearing on Reform of Dental Care in Medicaid
February 14, 2008
2154 Rayburn HOB
2:00 P.M.**

[Slide 1] One year ago, a twelve-year old boy named Deamonte Driver died of a brain infection caused by untreated tooth decay. Deamonte lived in Prince George's County, Maryland and was eligible for Medicaid, but he hadn't seen a dentist in more than four years.

In May 2007, my Subcommittee held a hearing to examine the circumstances that led to Deamonte's preventable death. Today, we will examine what corrective actions the Center for Medicaid and State Operations ("CMS") has taken since Deamonte's death to reform the pediatric dental program for Medicaid eligible children.

During our hearing last May, we learned that Deamonte's mother, Alyce Driver, tried to obtain oral health services for her son and his brothers. But there was a problem: there were no dentists available for her Medicaid-eligible children enrolled by United HealthCare Company ("United"). According to Laurie Norris, the Driver family

lawyer and a witness at last year's hearing, "it took one mother, one lawyer, one help line supervisor, and three case management professionals to make a dental appointment for one Medicaid child."

After the hearing, I instructed my Subcommittee staff to investigate the adequacy of the dental provider network available to Medicaid eligible children enrolled in the same managed care company that was responsible for Deamonte.

My Subcommittee investigated United's dental network and records of claims submitted for services rendered to United beneficiary children in 2006. Staff found that Deamonte was far from the only child in Maryland who hadn't seen a dentist in 4 or more consecutive years. In fact, nearly 11,000 Maryland children enrolled in United had not seen a dentist in four or more consecutive years, putting them in the same precarious position that Deamonte was in at the time of his death. The investigation also revealed that United's dental provider network was not nearly as robust as they claimed. We discovered that 55% of all dental services rendered in 2006 in the county where Deamonte resided were conducted by only seven dentists. We also discovered that nineteen of the dentists listed in the dental provider network in the County provided zero services to Medicaid-eligible children in 2006. United has concurred with all of the

Subcommittee's findings, and they are cooperating with the Subcommittee's broader investigation as well.

There is no dispute that federal law, specifically Section 1902 of the Social Security Act, mandates that Medicaid-eligible children are entitled to routine dental services and any necessary treatment on a periodic basis. Why then were no dentists available to deliver that care to Deamonte? More importantly, why didn't CMS, the federal agency responsible for administering Medicaid, do something about it?

At our hearing last May, we asked Mr. Dennis Smith, the Director of CMS, that question. We asked him why he did not take any action in Maryland after he learned that only 24 percent of its children got any dental care in 2004 and he responded:

[Slide 2] "The enforcement tools... are to sanction the State financially...I have not sanctioned states for the access issue in dental care."

He went on to say:

[Slide 3] “Enforcement is about taking financial penalties against states.”

But financial sanctions are absolutely not the only enforcement tools available to CMS.

The Director of CMS has many enforcement tools available to him and in a May 17th 2007 letter that Congressman Cummings and I sent to Mr. Smith, we enumerated just a few of them. We suggested that CMS:

[Slide 4]

- Conduct a critical incident review of Deamonte Driver's death
- Make children’s access to dental care a CMS enforcement priority and communicate this priority to all states
- Establish a standard or goal for the percentage of eligible children to receive preventive dental services
- Improve current reporting requirements, namely make the CMS-416 Forms more reliable and accurate
- Identify the poorest performing states and assess why those states are performing poorly and suggest ways they can improve their performance

- Rank the states in order of performance vis-a-vis the provision of dental care
- Ensure that administrators of Medicaid programs have ready access to the policy guidance they need in order to cover children's dental services with respect to reimbursement rates and managed care oversight
- Issue a letter to State Medicaid Directors reminding them of their legal obligations and ask them to submit "plans of actions" for ensuring that children will have adequate access to dental services
- Assess civil money penalties against any managed care organization that has contracted with a Medicaid agency and has failed to do so

What a difference a year makes.

Since our hearing, Medicaid has indeed used several tools to enforce federal law. We will learn about many of those actions today.

But time doesn't heal all wounds.

In important ways, Medicaid still hasn't learned the most important lessons from the preventable death of Deamonte Driver.

According to experts, one of the most important things that CMS can do is to address the issue of reimbursement rates at a national policy level.

In 2000, CMS contracted with the American Association of Pediatric Dentists (“AAPD”) to draft a *Guide to Children’s Dental Care in Medicaid* (“Guide”). The contract stipulated that the Guide was to provide policy guidance to the State Medicaid agencies about implementing and managing Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) system.

The AAPD submitted the completed Guide to CMS in 2001. However, CMS did not publish it until 2004, and when it did finally publish it [Slide 5] under the authority and leadership of Mr. Smith, the entire policy section on reimbursement rates and managed care oversight was redacted.

But why would Mr. Smith do that when at our hearing last year, he himself said that [Slide 6] “The key to improving access principally from the provider perspective, is to increase reimbursement rates.”

Clearly, Mr. Smith understands the nature of the problem *as well as* a cornerstone to its solution. Yet, as the Director of CMS, he failed to

use his understanding to solve that problem or, at the very least, to improve it.

In our letter to him, Congressman Cummings and I urged Mr. Smith to revise the Guide to incorporate information relating to provider reimbursement and managed care oversight that was edited out of the 2004 version. Alternatively, we asked him to send a State Medicaid Director letter that provided this critical policy information.

Mr. Smith refused both of our requests. He explained: **[Slide 7]**
“States have ready access to all Medicaid policy on reimbursement and managed care oversight through existing Federal publications and documents.”

We think that answer is unacceptable.

In Georgia, that information was available when its three managed care organizations cut their reimbursement and limited their dental services in 2006. That was a profit-boosting move on their part.

In Maryland, that information was available when Deamonte died of a brain infection caused by untreated tooth decay.

In the District of Columbia, Virginia, and twenty other states, that information has been available as Small Smiles—an abusive, possibly criminal, multi-state dental provider—preys on Medicaid-eligible children to generate a profit. Because inadequate reimbursement rates are often insufficient to cover even honest dentists' costs, Small Smiles conceived of another way to make a profit: a predatory mill where multiple, sometimes unnecessary, procedures are imposed assembly-line style on children with little regard for their welfare or proper dental practice. Small Smiles routinely barred parents from their children's side during dental procedures; and in separate instances performed more than a dozen root canals on a child's baby teeth, and in Arizona, fatally overdosed a child with anesthesia. While CMS certainly does not condone these unscrupulous and horrific practices, its silence on reimbursement rates creates the economic incentives for them to flourish.

CMS's role as a federal administrator of Medicaid is not *just* to have information available but to make sure that the states have and use that information and comply with federal law.

Prior to Mr. Smith's taking the reins at CMS, the former CMS Director understood this concept and issued a State Medicaid Director Letter requesting information on state efforts to ensure children's

access to dental services under Medicaid. The Letter indicated that CMS would undertake intensive oversight of states whose dental utilization rates, as indicated on the CMS-416 annual reports, were below 30 percent, including site visits by Regional Office staff. States with utilization rates between 30 and 50 percent would be subject to somewhat less stringent review. All states were asked to submit “Plans of Action” detailing how they would improve access to oral health care within three years. The Letter not only sent a message to states that oral health was a Medicaid priority but, that as the provider of half of the states’ Medicaid budgets, CMS was monitoring their performance closely.

Significantly, Maryland was among the states with utilization rate below 30 percent. But between 2001, when Maryland submitted that information to CMS, and February 2007, when Deamonte died, CMS, under the leadership of Mr. Smith, had done nothing to follow-up with those poorest performing states.

The new administration Maryland under Governor O’Malley has laudably taken the initiative since Deamonte Driver’s death. Maryland’s Medicaid Administration has taken a number of significant actions. They did that on their own, in light of all of the local attention Deamonte’s tragic death earned.

But what has CMS done nationally, in other states besides Maryland, to prevent the situation that led to Deamonte's death?

Today we will find out.

Mr. KUCINICH. With that, I am going to go and vote. I will be back and we will continue the hearing.

[Recess.]

Mr. KUCINICH. The committee will resume.

Mr. Smith, Dr. Crall, Dr. Edelstein, thank you for being here. I ask that you proceed. Thank you.

STATEMENTS OF DENNIS SMITH, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS; DR. JIM CRALL, DIRECTOR, ORAL HEALTH POLICY CENTER, PROFESSOR AND CHAIR, SECTION OF PEDIATRIC DENTISTRY; AND DR. BURTON EDELSTEIN, FOUNDING CHAIR, CHILDREN'S DENTAL HEALTH PROJECT, PROFESSOR AND CHAIR, SOCIAL AND BEHAVIORAL SCIENCES, COLUMBIA UNIVERSITY COLLEGE OF DENTAL MEDICINE

STATEMENT OF DENNIS SMITH

Mr. SMITH. Thank you, Mr. Chairman. I am happy to be with you again this afternoon. I will be very brief. We have a statement for the record, so I won't go through all of the detail that we have provided in terms of the steps that we have taken since the subcommittee hearing in may of 2007.

In the President's budget that came out last week, Medicaid spending, Federal and State combined, is estimated to exceed \$347 billion in fiscal year 2009, \$2 trillion over the next 5 years, \$5 trillion over the next 10 years. Total Medicaid spending on children will exceed \$400 billion over the next 5 and \$1 trillion over 10, which is approximately 20 percent of Medicaid's spending on children. We serve more than 29 million children in Medicaid. In 2009, the estimated per capita cost for a child for a full year on Medicaid is nearly \$2,900.

Medicaid is directly administered by the States. States enroll providers at reimbursement rates and negotiate managed care contracts. Medicaid is a matching program; Federal dollars follow State dollars. In general, we do not have separate authority to make direct grants to States for different activities, although Congress has periodically created specific grant programs, such as the Medicaid Transformation Grants under the Deficit Reduction Act of 2005, and the Real System Change Grants previous to that.

In terms of our response to the issues in Maryland specifically, as you are aware, we did perform a focused review of Maryland dental services that we began in October of last year. We have completed that review and submitted that to the subcommittee for its review. In general, CMS found that although Maryland took steps in 2007 to hold managed care organizations responsible for providing dental services, additional accountability and oversight was needed. The draft findings were issued on November 28th of last year, which included six findings and recommendations for the State to respond to.

Those recommendations centered on ensuring the individual that information provided to beneficiaries on accessing dental services was easy to find and culturally appropriate; establishing an internal service to independently verify MCO dental provider directories; instructing MCOs to track and report on children not receiv-

ing dental services and to escalate steps to reach such children; documenting the oral health needs of special needs children and the adequacy of dental specialists to meet their needs; requiring MCOs to monitor and report on dental provider utilization; and conducting appropriate reviews to determine the need to initiate appropriate corrective actions, including sanctions, against any MCO not meeting its contractual obligations.

In particular to the quote from the May hearing, I am concerned that the quote left the impression that we would not pursue sanctions. I want to assure you that we had—my recollection is—a general discussion, conversation with Mr. Waxman about it. If I gave the impression that we were taking sanctions off the table, I certainly did not mean to give that impression. We specifically raised the issue of sanctions in particular on the MCOs with Maryland and Maryland specifically needed to address whether or not sanctions needed to be taken. Maryland ultimately recommended that sanctions not be taken in the corrective actions of the MCOs in general and the work of the Dental Action Committee.

Maryland formed a Dental Action Committee last June with a broad variety of community leaders. I understand that Dental Action Committee has submitted a report to the Maryland General Assembly, which is ultimately responsible for providing the necessary funding to support the recommendations for increased reimbursement.

We will not be stopping with our work in Maryland. Although we have seen progress in the utilization of dental care for children in Medicaid, in 1996 only one in five children in families with income below 200 percent of the Federal poverty level had a dental visit the previous year. Our current CMS Form 416 data for 2006 showed that one in three individuals under age 21 received a dental service. That is an increase of 10 percent over 2003, 22 percent increase from 2000. But we agree that, certainly, further progress is needed.

In that respect, in our oversight role, we began a series of EPSDT dental reviews this week that will occur in 15 States between now and early April. CMS Central Office and Regional Office Staff—

Mr. KUCINICH. Mr. Smith, excuse me. I am sorry to interrupt your testimony, but since we have been joined by our ranking member, Mr. Issa, and since his presence now makes this an official meeting, what I would like to do is to ask you and all the others to stand and be sworn. You continue with your testimony and then if Mr. Issa has anything after Mr. Smith is complete, we will ask Mr. Issa to enter his statement.

So would you raise your right hands?

[Witnesses sworn.]

Mr. KUCINICH. Let the record show that the witnesses have answered in the affirmative. I thank you for your cooperation.

You may proceed, Mr. Smith.

And I thank Mr. Issa for his presence here.

Mr. ISSA. Thank you. And I apologize for not being here earlier.

Mr. KUCINICH. Listen, we are both in a tight schedule today, so it means a lot that you are here.

Mr. Smith, you will proceed. Then I will come back to Mr. Issa and then the other two witnesses. Go ahead.

Mr. SMITH. Thank you, Mr. Chairman.

As I just mentioned, we began a review that will occur between now and early April for 15 States. We have developed, and staff in the central office and the regional offices have now been trained, on a dental review protocol that will be used to assess States in seven key areas: informing families, periodicity schedules and inter-periodic services; access to dental services; diagnosis and treatment services; support services; coordination of care; and data collection, analysis, and reporting. These 15 States have been identified and, as I said, we began this week and we expect to issue final reports to the States during the summer.

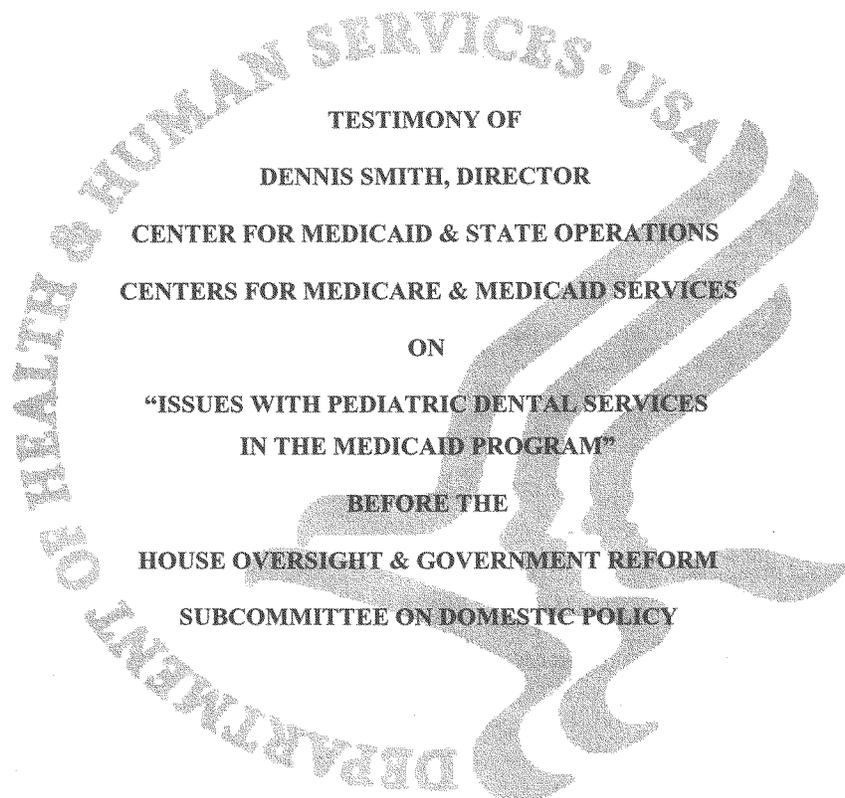
In my testimony, I have a list of a number of activities that we have undertaken. I won't go through all of those now, but they, I believe, demonstrate that we have taken action on the area of dental access and I believe that we have engaged the States appropriately in improving services to children, improving access to the dental care.

We believe that we have expanded both the use of the dental services among children and our ability to report on that progress, and this is an area that we often find ourselves in terms of gaps and information in our reporting systems. We are not always able to provide the data that policymakers and the subcommittee would like to have, and I have personally expressed my frustration many times on our ability to be able to report timely, accurately, and in the various different ways that we would want to be able to measure the real progress that we have taken.

I also, in terms of being able to respond to—the chairman raised an issue of practices that we have now seen in terms of inappropriate care of children, providing care that is not medically necessary and, in fact, may in fact lead to detrimental impact on children's health. We are very much aware of those and we are participating in those reviews, and I assure you that our program integrity group, in cooperation with Medicaid fraud control units and the Department of Justice are participating in those reviews.

Thank you again for inviting me this afternoon.

[The prepared statement of Mr. Smith follows:]



TESTIMONY OF
DENNIS SMITH, DIRECTOR
CENTER FOR MEDICAID & STATE OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
“ISSUES WITH PEDIATRIC DENTAL SERVICES
IN THE MEDICAID PROGRAM”
BEFORE THE
HOUSE OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON DOMESTIC POLICY

February 14, 2008



Testimony of Dennis G. Smith
Director, Center for Medicaid & State Operations
Centers for Medicare & Medicaid Services
on
Issues with Pediatric Dental Services
In the Medicaid Program
Before the
House Oversight & Government Reform
Subcommittee on Domestic Policy
February 14, 2008

Mr. Chairman, thank you for the opportunity to provide an update on the Centers for Medicare & Medicaid Services' (CMS) oversight of state performance and access to dental care for children who are served by the Medicaid program. There have been a number of important developments since my testimony before the Subcommittee in May 2007.

Background

Under the President's Budget released last week, Federal and State Medicaid spending for medical services is estimated to exceed \$347 billion in Fiscal Year (FY) 2009, \$2 trillion over the next five years, and \$5 trillion over the next 10 years. Total Medicaid spending on children will exceed \$400 billion over the next five years and \$1 trillion over ten years, which is approximately 20 percent of total spending over these time periods. We serve more than 29 million children in the program. The estimated total cost per child for a full year on Medicaid for all services in FY 2009 is nearly \$2,900. Medicaid payments for dental services are made both on a fee-for-service basis and through different types of managed care including both risk-based and non-risk based contracts

Medicaid is directly administered by the states. States enroll providers, set reimbursement rates, and negotiate managed care contracts. It is a matching program. Federal dollars follow state dollars. In general, we do not have separate authority to make direct grants

although Congress has periodically created specific grant programs such as the Medicaid Transformation Grants under the Deficit Reduction Act of 2005.

Review of Maryland Compliance

As you are aware, CMS performed a focused review of Maryland Medicaid dental services on October 18, 2007. In general, CMS found that although Maryland took steps in June 2007 to hold the managed care organizations (MCO) responsible for providing dental services to children, additional accountability and oversight was needed. The draft findings report that was issued to the Maryland Medicaid Director on November 28, 2007 included six findings and recommendations for which the state was to respond within 30 days. Recommendations centered on ensuring that information provided to beneficiaries on accessing dental services was easy to find and culturally appropriate; establishing an internal system to independently verify MCO dental provider directories; instructing MCOs to track and report on children not receiving dental services and to escalate steps to reach such children; documenting the oral health needs of special needs children and the adequacy of dental specialists to meet their needs; requiring MCOs to monitor and report on dental provider utilization; and conducting appropriate reviews to determine the need to initiate appropriate corrective actions, including sanctions, against any MCO not meeting contractual obligations.

Maryland's Medicaid Administration has acknowledged the inadequacies of their dental network and has taken steps to strengthen requirements placed on their MCOs. Our final report was submitted to Maryland last week and a copy was submitted to the Subcommittee. We will conduct a follow-up review when the state has had sufficient time to implement the various recommendations.

As the Subcommittee knows, Maryland formed a Dental Action Committee last June with community leaders. I understand that the Dental Action Committee has submitted a report to the General Assembly which ultimately is responsible for providing the necessary funding to support the recommendations for increased reimbursement.

Expanding the Reviews

States have made progress in increasing access to dental care for children in Medicaid. In 1996, only 1 in 5 children in families with income below 200 percent of the federal poverty level had a dental visit in the previous year according to data provided in *Healthy People 2010*. Current CMS Form-416 data for FY 2006 show that 1 in 3 individuals under age 21 received a dental service during the year. This is an increase of 10 percent since year 2003 data and a 22 percent increase from the year 2000 data. However, the national *Healthy People 2010* objective has set a target of the proportion of children who use the oral health care system each year at 56 percent. Clearly further progress is needed.

States monitor access to dental services through a variety of mechanisms including review of claims data to determine over or under utilization, review of Health Plan Employer Data and Information Set (HEDIS) performance measures related to dental access, monitoring hotline calls, reviewing grievances for complaints related to dental services and through discussions with dental providers in their areas.

There are limits to the information that is available from the current data collection systems at the national level. States submit aggregated data with respect to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program on CMS-416; this does not provide information on an individual basis so it is not possible to use it to produce longitudinal data to track individuals over multiple years. We have also made significant improvements in the Medicaid Statistical Information System (MSIS) which contains State-specific files. These files include individual/eligibility and service claim specific information when provided on a fee-for-service basis, but do not include such information for coverage through managed care plans. Given the significant proportion of children in Medicaid who are served through managed care plans, a longitudinal analysis would have severe gaps. Finally, it currently takes about two years for validated MSIS data with respect to a particular fiscal year to become available.

In our oversight role, we began a series of EPSDT dental reviews this week that will occur in 15 states between now and early April. CMS Central Office and Regional Office staffs have developed and been trained on a dental review protocol that will be used to assess state

efforts in seven key areas: informing families, periodicity schedules and interperiodic services, access to dental services, diagnosis and treatment services, support services, coordination of care, and data collection, analysis, and reporting. These 15 states have been identified as the states with the lowest percent of children receiving a dental service based on 2006 reporting. We expect to issue final reports to the states during the summer.

Strengthening the Medicaid Partnership in Dental Care

CMS has been working on several projects to improve access to dental care for Medicaid eligible children. Here are some of the actions that we have taken regarding our oversight of the program to increase access to quality dental care for children:

- I personally discussed oral health issues with the State Medicaid Directors at a June 2007 National Association of State Medicaid Directors' (NASMD) meeting and again with the Executive Committee in November 2007 and requested their assistance in renewing their focus on oral health care. Additionally, the Director of Quality, Evaluation and Health Outcomes was a presenter at the November 2007 NASMD meeting and addressed the importance of oral health access. As a result of these discussions, NASMD has agreed to convene an Oral Health Technical Advisory Group (TAG) with us. The TAG will address numerous issues related to oral health services including access and quality.
- The importance of CMS-416 reporting and access to dental care was highlighted with the States during a May 23, 2007 and January 23, 2008 meeting of the Quality Technical Advisory Group with State Medicaid Directors and their staffs. Additional discussions were held with the Medicaid Medical Directors during their November 8, 2007 and February 7, 2008 national meetings. On all of these occasions, CMS' expectations related to ensuring access to dental services were reinforced. During that time, states were also informed of the focused dental reviews that are underway.
- CMS held meetings with all the Regional EPSDT/Dental Coordinators on June 28, 2007 and January 23, 2008, to discuss the importance of providing technical assistance to and oversight of States in the area of CMS-416 reporting for EPSDT and dental services. We also gave direction on the sharing of best practices and the importance of monitoring activity within the States.

- We have worked aggressively to ensure the submission of dental services data on the CMS-416 so that we can continue to analyze and monitor progress in the provision of dental services. The 2006 data was due in April 2007. On June 14, 2007, we sent letters to 22 States that had not submitted complete EPSDT CMS-416 annual data for one or more years. In addition to sending formal requests for overdue data, the Regional Offices contacted these states to determine why the data had not been submitted and to provide technical assistance for problems with collection methodology. Because of these efforts, CMS received data from all but two states (ME and WV). We have issued a request for immediate resolution in those two states. We continue to work with three other states on the accuracy of their data.
- The Director of the Medicaid Quality Division of the Center for Medicaid and State Operations (CMSO) and the CMS Chief Dental Officer have held a series of meetings with the American Dental Association (ADA) to discuss access and quality measurement in dental care. They have also had a similar conversation with the American Academy of Pediatric Dentistry and the Medicaid and SCHIP Dental Association. As a result of these actions, they have been invited to serve as presenters at the National Oral Health Conference that will be held April 28-30, 2008. This conference is sponsored by the American Association of Public Health Dentistry and the Association of State and Territorial Dental Directors. This will present an excellent opportunity to share the findings from the CMS-416 data, share results from the focused dental reviews, and determine how to work together to improve access in the future and to keep the momentum going forward.
- CMS is also in discussion with the Association for Community Affiliated Plans (ACAP) to identify promising dental practices through their membership. ACAP is made up of 29 health plans including 12 Special Needs Plans, in 15 States, which are primarily focused on Medicaid, Medicare and SCHIP populations.
- CMS also holds a series of national Quality Teleconference Calls that averages over 400 participants from across the country. The Spring 2008 Quality Teleconference Call has been scheduled for April 3, 2008 and will focus on promising practices in children's dental care. This will include innovative approaches to financing dental care.

- On November 15, 2007, CMS sponsored an “all-state Medicaid dental managers” conference call to increase awareness of the issues related to payment for Medicaid pediatric dental services.
- Last year we also established a Medicaid Quality Improvement Goal to improve states’ abilities to assess quality of care and move toward the development of a national framework for quality. We have developed a comprehensive state-specific Quality Assessment Report that provides an analysis of nearly every quality activity occurring in a state Medicaid or SCHIP program. Dental services are included among the various performance areas. We completed the Assessment Report for North Carolina and issued it to the State in January. We are currently awaiting a formal response from the State; however, preliminary feedback from the State was very positive and they indicated that this report will serve them well as a tool in their quality improvement efforts. We intend to expand the analysis to at least seven other states this year.
- CMS has created a Web site where we highlight “promising practices.” We currently have dental promising practices posted from South Carolina, Tennessee, and Virginia and are working on information from several other States that we hope will also be disseminated via the Web page. The link to the promising practices Web page is: <http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/MSPPDL/list.asp#TopOfPage>.

Conclusion

Together, these actions demonstrate our commitment to effective oversight and enforcement of access to dental care. We believe they will increase access including screening rates.

Compared to previous years, we have demonstrated steady progress in expanding use of dental services among children and in our ability to report such progress to the public. We know our work is not over and we must remain vigilant and proactive. Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.

Mr. KUCINICH. Thank you very much, Mr. Smith. I appreciate your presence here and your willingness to cooperate with us. Thank you.

Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman. Once again, I would like to apologize for the overlapping schedule of multiple committees. Mr. Chairman, I want to personally thank you for doing what this committee should do, which is to hold hearings, shed light on a problem that exists, particularly within Government-managed programs, and then give Government management an opportunity to work on those problems, and last, as today, to come back and tell us what they have done to see whether or not we need to address it further.

Certainly, I think that this will not be the last visit on health care, Government-sponsored health care before this committee. I am confident that as we seek to deal with the problems not just of S-CHIP and other Federal programs, but the broader problem of health care availability in this country and, as Mr. Smith said,—and I couldn't agree with you more—the fact that under-medication and over-medication can occur separate from whether or not there is insurance. These problems and more need the constant attention of professionals at the front line and then periodic review by this committee and others.

So I want to thank the chairman for bringing this up today. This is an issue that we are both passionate about. We both, sadly enough, are Clevelanders and come from an area that today is suddenly in greater need of these kinds of services and more.

So with that, Mr. Chairman, I would ask unanimous consent to put my entire opening statement in the record and go on to the rest of the hearing.

Mr. KUCINICH. I appreciate that. I look forward to having your entire statement in the record. And, again, the Chair wants to state how much I appreciate our working partnership here in the public interest. Thank you.

Before we move on, does the gentlelady from California have anything that she wants to say?

Ms. WATSON. I want to thank the chairman for holding this important hearing on reforming the pediatric dental program for Medicaid-eligible children.

In 2007, the subcommittee held a hearing on the unfortunate death of Deamonte Driver, a 12-year-old boy from Prince George's County, Maryland, who died of a brain infection caused by tooth decay. Deamonte's death shines light on our Nation's Medicaid program that has become increasingly unglued due to the fact that fewer and fewer dentists are willing to take Medicaid patients. As noted in the 2007 hearing, Prince George's County has approximately 45,00 to 50,000 child Medicaid participants, some 200 dental offices that are listed as Medicaid providers. But, in reality, only 25 percent, or 50 offices actually see child Medicaid patients. The ratio of patients to providers is obviously unacceptable.

It pleases me that the subcommittee has continued its oversight of the Center for Medicaid and State Operations since the 2007 hearing and has provided the members of the subcommittee with a brief update on its ongoing investigation. The committee memo-

randum notes, quite disturbingly, “On October 2nd, 2007, the subcommittee issued its review of United’s documents and revealed that nearly 11,000 Maryland children enrolled in the United had not seen a dentist in four or more consecutive years, putting them in the same precarious position that Deamonte was in at the time of his death.”

The review also revealed that United Health Group Companies, the health company that manages the CMS program, dental provider network was not nearly as robust as they had claimed. Fifty-five percent of all dental services rendered in 2006 in the country were conducted by only seven dentists.

So, Mr. Chairman, we see, in 1 year, that the basic situation has not changed that much. Thousands of children in Maryland alone—and undoubtedly hundreds of thousands of children across the Nation—are in danger of having their health systems seriously compromised at a young age due to lack of access to dental care. So I look forward to the hearing and to hearing from the witnesses as to how we go about fixing a serious problem that will have health consequences for many of these same children who reach adulthood decades later. The age-old adage by Ben Franklin “an ounce of prevention is worth a pound of cure” is certainly applicable to the situation we have before us today. So thank you so very much.

[The prepared statement of Hon. Diane E. Watson follows:]

**STATEMENT
OF
CONGRESSWOMAN DIANE WATSON**

**Domestic Policy Subcommittee
Oversight and Government Reform Committee
Thursday, February 14, 2008
2154 Rayburn HOB
2:00 P.M.**

Opening Statement- Subcommittee Hearing on Adequacy of Federal Reform of the Pediatric Dental Program for Medicaid Eligible Children Since the Death of Deamonte Driver

Mr. Chairman, thank you for holding this important hearing on reforming the Pediatric Dental Program for Medicaid Eligible Children. In 2007, the Subcommittee held a hearing on the unfortunate death of Deamonte Driver, a twelve year old boy from Prince Georges County, Maryland, who died of a brain infection caused by tooth decay.

Deamonte's death shines light on our nation's Medicaid program that has become increasingly unglued due to the fact that fewer and fewer dentists are willing to take Medicaid patients. As noted in the 2007 hearing, Prince George's County has approximately 45,000 to 50,000 child Medicaid participants, some 200 dental offices that are listed as Medicaid providers, but in reality only 25%, or 50 offices, actually see child Medicaid patients. The ratio of patients to providers is obviously unacceptable.

It pleases me that the Subcommittee has continued its oversight of the Center for Medicaid and State Operations (CMS) since the 2007 hearing and has provided the Members of the Subcommittee with a brief update of its ongoing investigation. The Committee memorandum notes, quite disturbingly, and I quote "On October 2, 2007, the Subcommittee issued its review of United's documents and revealed that merely 11,000 Maryland children enrolled in United had not seen a dentist in four or more consecutive years putting them in the same precarious position that Deamone was in at the time of his death. The review also revealed that UnitedHealth Group Company's (the health company that manages the CMS program) dental provider network was not nearly as robust as they claimed:

55/0 of all dental services rendered in 2006 in the country were conducted by only seven dentists.”

So, Mr. Chairman, we see in one year that the basic situation has not changed that much. Thousands of children in Maryland alone, and undoubtedly hundreds of thousands of children across the nation, are in danger of having their health systems seriously compromised at a young age due to lack of access to dental care.

I look forward to hearing from the witnesses today and how we can go about fixing a serious problem that will have health consequences for many of these same children who reach adulthood decades later. The age-old adage by Ben Franklin, “an ounce of prevention is worth a pound of cure,” is certainly applicable to the situation we have before us today.

Mr. KUCINICH. I want to thank the gentlelady from California for her participation and let you know that Mr. Smith had already given his testimony when Mr. Issa arrived. Out of fairness, I wanted to make sure that you had a chance to submit your statement, and you have, and I am grateful for that.

We are going to proceed with Dr. Crall, and you are welcome to stay as long as you would like, of course.

Dr. Crall, you may proceed, and thank you.

STATEMENT OF DR. JIM CRALL

Dr. CRALL. Thank you, Mr. Chairman and members of the subcommittee for the opportunity to participate. My testimony is organized into three sections corresponding to requests in your letter of February 4, 2008.

I will begin with a quick overview of the significance of oral health to overall health, which has been extensively documented in scientific publications, governmental reports, including the Surgeon General's Report on Oral Health.

Oral diseases and developmental disturbances are common afflictions for children and adults. Tooth decay, often referred to as dental caries, is the most common chronic disease of childhood. Over 50 percent of U.S. children experience tooth decay by the time they enter kindergarten and nearly 80 percent by late adolescence. Children covered by Medicaid and other public programs acquire this disease early in life, have higher rates of caries and more severe forms of the disease and greater unmet treatment needs. The early onset of caries, especially in low-income children, underscores the importance of providing ongoing dental care and what we refer to as a dental home beginning early, that is, by age one.

Gingivitis, inflammation of the gums, also common in children, can progress to periodontal disease, which is an inflammatory disease that destroys bone and spreads infection. Infants, children, and adults also experience a wide variety of developmental abnormalities, such as cleft lip and cleft palate and abnormal formation of teeth and jaws. Also, in adults, oral and pharyngeal cancers are relatively common.

The consequences of oral diseases and development disturbances can be profound for overall health and quality of life. The infectious disease that causes tooth decay can spread to the bloodstream and lymph system. These infections cause pain, swelling, loosening of teeth, and can spread to other areas of the body, such as the brain, heart, and lungs; and they can trigger serious co-morbidities. The death of Deamonte Driver is a tragic reminder of the potential consequences of untreated tooth decay. Periodontal disease is also caused by bacteria that can spread throughout the body and has been associated with a variety of conditions, including cardiovascular disease, type 2 diabetes, adverse pregnancy outcomes, pneumonia, and osteoporosis. Developmental disturbances such as cleft lip and cleft palate and oral cancers have obvious impacts on individuals' ability to speak, eat, their appearance, self-esteem, and social interactions, as can tooth decay and periodontal disease, especially for individuals of low, socio-economic status.

The messages of the Surgeon General's Report on Oral Health have not been effectively translated into public policy or public pro-

grams. Despite Federal EPSDT statutes, access to dental services for children covered by Medicaid remains a significant chronic problem. Most States and Medicare do not coverage for basic restorative dental services for adults. Failure to implement the Surgeon General's findings in public programs via legislative authority and appropriations, regulatory oversight, and effective program implementation remains a significant detriment to overall health and quality of life for millions of U.S. children and adults.

Next, I would like to turn to the importance of reimbursement rates to ensuring access to dental care among Medicaid beneficiary children. Regular dental care is one of three key elements considered to be central to sustaining good oral care. The other two have to do with dietary practices and what we call oral hygiene or self-care routines. Access to ongoing dental care is especially important for children at elevated risk for common dental diseases, that is, children in low-income families and children with special health care needs who generally are covered by Medicaid.

Reimbursement that is sufficient to engage in adequate number of dental professionals having the knowledge and skills to meet the full range of dental care needs of Medicaid children is fundamental to ensuring access and sustaining good oral health. Approximately 24 million children were enrolled in Medicaid each month in 2007. Providing access to ongoing dental services for this large number of children requires that a very substantial number of private sector dentists—who provide over 90 percent of dental services—as well as public sector—often referred to as safety-net dentists—be engaged as Medicaid participating providers in each State.

Could I have the first slide, please?

[Slide shown.]

Dr. CRALL. Studies conducted by Federal agencies report that inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid. GAO reports note that Medicaid payment rates often are well below dentists' prevailing fees and that, as expected, payment rates closer to dentists' full charges appear to result in improvement in service use.

[Slide shown.]

Dr. CRALL. This slide shows trends in total U.S. dental expenditures and Medicaid dental expenditures following enactment of Federal Medicaid legislation in 1965. The dark blue line depicts total U.S. spending on dental services. The yellow line represents aggregate public expenditures for dental services, largely Medicaid.

With a few recent exceptions, chronic under-funding over a period of several decades has translated into reimbursement rates that provide limited or no financial incentives for most dentists to participate as Medicaid providers in most States.

Medicaid programs frequently base reimbursement schedules on a fundamentally flawed application of the concept of usual, customary, and reasonable fees, which does not provide a valid reflection of market-based dental fees for several reasons, which are detailed in my written testimony. Moreover, most Medicaid programs have no provisions for updating fee structures on a regular basis for inflation.

And if I could have the next slide.

[Slide shown.]

Dr. CRALL. This slide illustrates a 50 percent loss in purchasing power over a 14-year period. Unfortunately, it is an interval which is not uncommon for Medicaid rate adjustments in many States, with a 5 percent annual inflation rate.

[Slide shown.]

Dr. CRALL. Next slide shows the effects of applying discounts of 17 percent or 35 percent to dentists' average charges. The results are reimbursement rates that are below, and often substantially below, the usual charges of 75 percent to 90 percent of dentists. And, beyond that, discounts of over 50 percent off of average charges are not uncommon in State Medicaid programs.

Next slide, please.

[Slide shown.]

Dr. CRALL. Beginning in the late 1990's, following a series of oral health policy academies organized by the National Governors Association, several States moved to increase Medicaid reimbursement rates to levels consistent with market-based approach. As the GAO noted, Medicaid payments that approximate prevailing private sector market fees did result in substantial increases in dentists' participation in Medicaid, as shown on this slide.

[Slide shown.]

Dr. CRALL. More directly to the point, the next slide shows data from CMS 416 reports illustrating substantial increases in utilization in five States subsequent to rate increases that approach market-base levels.

[Slide shown.]

Dr. CRALL. And my final slide provides a comparison of one State's Medicaid payment rates for illustration. This State's Medicaid program paid \$18.08 for a periodic examination, an amount that only 2 percent of dentists in this State would see as equal to or greater than their current charges. It is the second percentile of fees.

Of particular note, for 9 of the 15 selected procedures on this slide, the respective Medicaid payment rates are less than the usual charges reported by any dentist in this State. They are less than the first percentile of fees. From an economic perspective, these payment levels would not provide adequate incentives for dentists to participate in Medicaid.

Finally, I was asked to comment on CMS's redaction of the section on policy guidance relating to provider reimbursement and managed care oversight in the Guide to Children's Dental Care in Medicaid that I authored for the American Academy of Pediatric Dentistry. I will just point out that the entire section of the document that AAPD submitted to what was then HCFA, now CMS, on program financing and payments, Section C in the submitted table of contents, was deleted from the published version of the Guide. That material primarily related to the previous statements on reimbursement.

Additional information was provided in the redacted sections on relevant actuarial studies, which showed that roughly \$14 to \$17 in 1998 or 1999 dollars per enrolled beneficiary, often referred to as PMPM, would be necessary to pay for dental services for children enrolled in Medicaid at market rates comparable to those used by commercial dental benefit plans for employer-sponsored

groups, or \$17 to \$20 PMPM for administering a Medicaid dental benefits program.

This information was included to provide a guide or benchmarks that State Medicaid programs could use to assess their current allocation levels for dental benefits for children enrolled in Medicaid. Available information suggests that many States allocate only a small fraction of the financial resources suggested by these actuarial studies. Some were on the order of \$5 to \$7 per child per month.

Other sections that were redacted included information on a number of topics that have potential relevance to the program administration and managed care organizations, such as legislative and regulatory requirements; basic program requirements; screenings and referrals for diagnosis and treatment; reimbursement for behavior management; integration of dental services and EPSDT screening services; continuity of care and case management; and contracts, development, and enforcement.

Two appendices on actuarial estimates and a document developed by a joint HCFA-HRSA-supported Maternal and Child Health Technical Advisory Group on Policy Issues in the Delivery of Dental Services to Medicaid Children and Their Families also were not included.

These sections were included in the version submitted by AAPD because, at the time, information on these topics, as well as differences between how medical and dental benefits are organized and financed, were not well known or understood by State policymakers, especially those who are not dental professionals. This information could have helped State officials understand important aspects of the dental care delivery system and how it relates to Medicaid policies, especially in the absence of regulations corresponding to changes made in OBRA 1989 that were never carried out.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Crall follows:]

WRITTEN TESTIMONY

Submitted by
James J. Crall, DDS, ScD
for the
U.S. House of Representatives
Committee on Oversight and Government Reform
Domestic Policy Subcommittee Hearing
On February 14, 2008
“One Year Later: Medicaid’s Response to Systemic
Problems Revealed by the Death of Deamonte Driver”

I, James J. Crall, D.D.S., Sc.D., hereby submit the following as written testimony pursuant to the Subcommittee’s request for information in conjunction with a hearing scheduled for Thursday, February 14, 2008, at 2:00 p.m., in Room 2154 of the Rayburn House Office Building. My statements are organized into three sections corresponding to specific requests contained in a February 4, 2008 letter from Chairman Kucinich.

1. Significance of Oral Health to Overall Health

The significance of oral health to overall health has been extensively documented in scientific publications and duly noted in reports issued by the Office of the U.S. Surgeon General (*see Oral Health in America: A Report of the Surgeon General, 2000*), numerous other federal and state agencies, and professional organizations involved in health care and public health. Oral health is significant to overall health for many reasons, including but not limited to those that are summarized below.

Oral Diseases, Pathology and Developmental Disturbances Are Common Afflictions

Oral diseases are among the most common chronic conditions affecting U.S. children and adults. Tooth decay (often referred to as dental caries) is the most common chronic disease of childhood. Caries is an infectious, transmissible disease that is initiated when certain acid-producing, decay-causing bacteria are transferred from the mouths of primary caregivers (usually mothers) to infants within the first few months of life through contact with saliva. Caries in preschoolers is often called Early Childhood Caries (ECC) and can cause severe damage to teeth and infections which affect other parts of the body. Children as young as one year of age experience tooth decay, underscoring the importance of early initiation of dental care which includes counseling for parents and caregivers. State and national surveys show that over 50% of children show evidence of tooth decay by the time they enter kindergarten and that nearly 80% of children experience caries by late adolescence. Surveys also repeatedly show that children from low-income families, who often are covered by Medicaid and other public programs, have higher rates of caries, acquire the disease early in life, have more severe forms of the disease, and have greater levels of unmet treatment needs.

Gingivitis or inflammation of the ‘gums’ or gingiva also is common in children, and can progress to periodontal disease (an inflammatory disease that leads to destruction of bone surrounding the teeth). Infants, children and adults also experience a wide variety of developmental abnormalities such as cleft lip and palate, abnormal formation of the teeth and jaws, abnormal eruption of teeth

and soft-tissue disturbances (e.g., cysts, tumors), which collectively have a relatively high cumulative prevalence within the population. Oral and pharyngeal cancers also are relatively common in adults.

Oral Diseases, Pathology and Developmental Disturbances Can Have Significant Consequences for Overall Health and Quality of Life

Common oral diseases such as tooth decay and periodontal disease have consequences which extend far beyond the teeth and jaws. The infectious process that causes tooth decay can spread to the bloodstream, lymph system and tissues both in the mouth and beyond (a condition often referred to as cellulitis). These infections cause pain, swelling and loosening of the teeth within the mouth, and can spread to other areas within the body (e.g., brain, heart, lungs) and trigger serious co-morbidities and even death if not treated in a timely, effective manner. The death of Deamonte Driver is a tragic reminder of the potential consequences of untreated tooth decay. Periodontal disease also is caused by specific bacteria that can enter the blood stream and lymphatic system and spread to other parts of the body. Periodontal disease is much more common in adults, particularly older adults, and in children with special health care needs (CSHCN), and has been associated with a variety of systemic health conditions including but not limited to: cardiovascular disease, type 2 diabetes mellitus, adverse pregnancy outcomes, pneumonia and osteoporosis. Developmental disturbances such as cleft lip and palate and oral cancers have obvious significant impacts on individuals' ability to speak, ability to eat, appearance, self-esteem, and social interactions (including employability in adults). Although less well appreciated, the more common dental conditions, such as tooth decay and periodontal disease, can have the same significant negative impacts on quality of life. As is the case with childhood caries, these conditions are more common in individuals of lower socioeconomic status -- i.e., those generally covered by public health care benefits programs.

Oral Health and Oral Health Care in the Context of Federal and State Public Policy

Although the frequency and consequences of oral diseases, pathology and developmental disturbances have been well documented and continue to receive considerable attention in the scientific community, the messages of the Surgeon General's Report on Oral Health -- that oral diseases are highly prevalent, that wide oral health disparities exist in America, and that oral health is essential to overall health -- have not been effectively translated into public policy or public programs in the U.S. Despite statutes that provide substantial authorization and direction for conducting programs that emphasize early and ongoing delivery of dental services for children subject to Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, access to dental services for children covered by Medicaid remains a significant, chronic problem that has been documented by a variety of federal agencies including the U.S. Department of Health and Human Services Office of the Inspector General (1996) and the General Accounting Office (2000). Additionally, most states do not provide coverage for basic dental services (i.e., basic services necessary to diagnose, prevent and treat common conditions such as tooth decay or periodontal disease) for low-income adults, individuals with intellectual disabilities or other special health care needs, or pregnant women. Likewise, basic dental services and other oral health services are not included in Medicare benefits. At a time when the majority of Americans enjoy the benefits of good oral health gained through knowledge of effective self-care habits and access to effective oral health care services, the failure to implement the findings of the Surgeon General's Report on Oral Health in public programs -- via legislative authorization and appropriations, regulatory oversight and

effective program implementation -- remains a significant detriment to overall health and quality of life for millions of U.S. children and adults.

2. The Importance of Reimbursement Rates to Ensuring Access to Dental Care Among Medicaid Beneficiary Children

Regular dental care is one of three key elements which are generally considered to be central to sustaining good oral health (the other two being healthy dietary practices and regular personal oral health habits, such as daily brushing with fluoride toothpaste and other 'oral hygiene' practices). Access to an ongoing source of dental care is especially important for children at elevated risk for common chronic dental diseases such as dental caries, e.g., children in low-income families and children with special health care need, who generally are covered by Medicaid and other public programs. Mounting scientific evidence concerning the early onset of dental caries during infancy and the importance and effectiveness of early interventions (such as early establishment of a "dental home" capable of providing the basic primary dental care that children need) have been emphasized in policy statements issued by organizations including, but not limited to: the American Academy of Pediatric Dentistry (AAPD), American Academy of Pediatrics (AAP), American Dental Association (ADA) and American Public Health Association (APHA). Reimbursement (or payments to providers for services rendered) that is sufficient to engage an adequate number of providers having the knowledge and skills to meet the full range of dental care needs of children of all ages is fundamental to ensuring access and sustaining good oral health for all children, but particularly for children covered by Medicaid for the reasons noted below.

Large Numbers of Children Enrolled in Medicaid

CMS data indicate that nearly 30 million children or roughly 1-in-3 American children were enrolled in Medicaid for at least some portion of 2007. Average monthly enrollment of children in Medicaid was approximately 24 million in 2007. Providing access to ongoing basic dental services for this large number of children requires that a very substantial number of dentists be engaged as Medicaid participating providers in each state and jurisdiction. The magnitude of services required to adequately meet the needs for dental services for children enrolled in Medicaid means that large numbers of private-sector dentists (who provide over 90 percent of all dental services) and public-sector (or "safety-net") dentists and members of their office/clinic support staff teams must be engaged as Medicaid providers in each state.

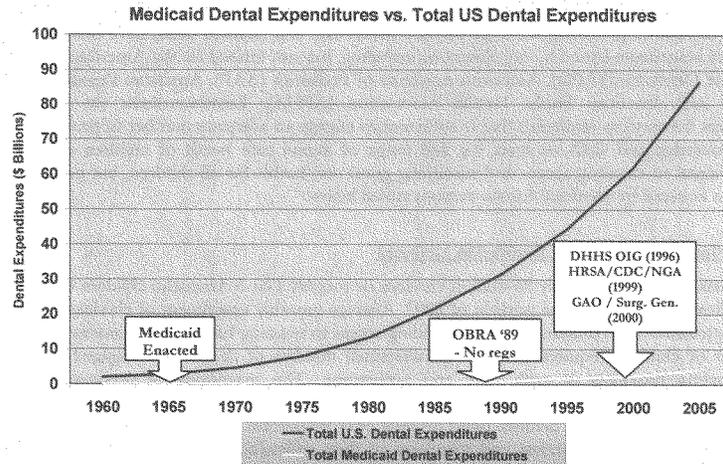
Financing, Budget and Reimbursement Decisions and their Relationship to Access to Dental Services for Children Enrolled in Medicaid

Access to dental services for children covered by Medicaid is a significant, chronic problem. Studies conducted by the U.S. Department of Health and Human Services¹ report that relatively few children covered by Medicaid receive recommended dental services and inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid. Reports issued by the U.S.

¹ Office of the Inspector General (OIG), U.S. Department of Health and Human Services. Children's Dental Services Under Medicaid: Access and Utilization. San Francisco, CA: U. S. Department of Health and Human Services, 1996.

General Accounting Office^{2,3} (GAO) to Congress in 2000 note that Medicaid payment rates often are well below dentists' prevailing fees. The GAO also noted that "as expected, payment rates that are closer to dentists' full charges appear to result in some improvement in service use."

Reimbursement rates are closely tied to financing and budget decisions made at the level of state governments. The figure below shows trends in total U.S. dental expenditures and Medicaid dental expenditures following enactment of federal Medicaid legislation in 1965. Subsequent revisions were made as part of OBRA '89 legislation due to concerns about implementation of state Medicaid programs, but the development of corresponding regulations did not occur. Additional actions noted above involving the DDHS OIG, GAO, NGA and Surgeon General occurred around the turn of the century.



The yellow line represents aggregate public expenditures for dental services -- now largely EPSDT dental benefits for children since many states have reduced or eliminated their adult dental Medicaid programs in recent years. State budget decisions for Medicaid dental programs determine the resources available for program operations and influence reimbursement rates. Chronic underfunding translates into reimbursement rates that provide little in the way of financial incentives for dentists to participate as Medicaid providers.

² General Accounting Office (GAO). Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations; U.S. General Accounting Office, Report to Congressional Requesters. HEHS-00-72, April 2000.

³ General Accounting Office. Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations; U.S. General Accounting Office, Report to Congressional Requesters. HEHS-00-149, September 2000.

Problems with Common Approaches for Establishing Medicaid Reimbursement Rates⁴

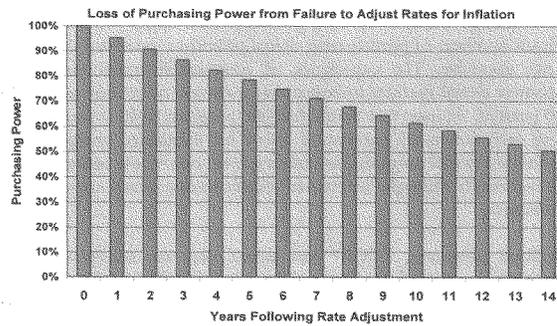
In many State Medicaid programs, administrators have based their reimbursement schedules on a fundamentally flawed application of the concept of “Usual, Customary and Reasonable” (“UCR”) fees. In the commercial dental benefits sector, application of the UCR concept usually means that individual dentists submit claims reflecting their usual charges to dental plans for procedures provided to covered beneficiaries, and the dentist is reimbursed either in full or at a modest discounted level of their submitted charges, up to a predetermined upper fee limit. This method generally results in significant numbers of participating dental providers, provided that the discounts on submitted fees are not excessive. The experience of commercial dental preferred provider networks in heavily competitive dental markets indicates that some providers may accept discounted fees in the range of 15-20 percent. At least one State Medicaid program (DE) is using this approach for reimbursement, paying each dentist 85 percent of his or her submitted charges as part of its efforts to transform its Medicaid dental program for children from one where access to services was formerly available almost exclusively through “safety net” clinics to one which engages a substantial portion of private-sector dentists.

More commonly in Medicaid programs, “UCR” has meant that the administrator bases the reimbursement schedule on the average fee submitted by all Medicaid participating dentists for procedures provided for Medicaid enrollees. The figure is often obtained from the State’s Medicaid data base. This approach to establishing Medicaid reimbursement does not provide a valid reflection of market-based dental fees for several reasons:

- The so-called “UCR” rate is actually less than the fees charged by 50 percent of dentists who submitted claims for Medicaid enrollees (i.e., those dentists whose fees are above the average charge submitted to Medicaid).
- Medicaid programs often apply a discounted rate substantially greater than that used in commercial dental benefit programs, resulting in fees-for-services that are substantially less than prevailing fees. (The figure below demonstrates that greater discounts result in fewer dentists viewing Medicaid fees as acceptable or reasonably comparable to their usual fees.)
- Many dentists submit charges to Medicaid that are equal to the amount Medicaid currently pays for a given procedure, rather than the charges they actually bill their non-Medicaid clients. This custom relates to the dentists’ recognition that they are bound by law to accept the Medicaid fee as payment in full for any covered procedure, and that billing Medicaid at the Medicaid fee instead of their usual charge eliminates the need to reconcile or “write-off” the difference for each procedure provided. There is no incentive for dentists to make this accounting adjustment because they cannot “balance bill” Medicaid clients for the difference between Medicaid and their private-sector fees, as they would for their private sector clients.
- Most States’ Medicaid fee data bases are at least one year behind the private sector market because they contain fees submitted by dentists in the prior year. Additionally, and perhaps more importantly, most Medicaid programs have no provisions for updating fee structures on a

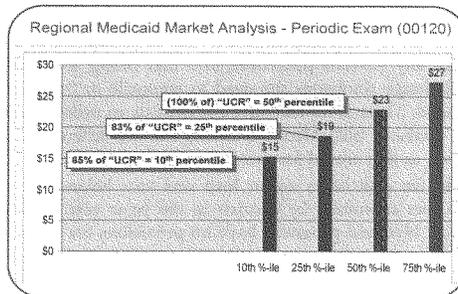
⁴ Adapted from: Crall JJ, Schneider DA. Medicaid Reimbursement – Using Marketplace Principles to Increase Access to Dental Services. (Series of 10 regional policy briefs on this topic prepared for publication by the American Dental Association) March, 2004.

regular basis for increases in the costs of producing services (i.e., inflation). Within a few years, the effect of not adjusting for the increase in the market prices for dental services is quickly compounded and the gap between Medicaid payments and prevailing charges becomes wide. The chart below illustrates the loss of purchasing power over a 14-year period at an annual inflation rate in the cost of dental services of 5% (typical in recent times). Such intervals in providing adjustments for Medicaid reimbursement rates are not uncommon.



The effect of Medicaid fee setting processes using UCR was described in a study cited by GAO investigators in their April 2000 Report to Congress. This study compared a sample of dentists' fees in the private sector to Medicaid fees for the same services, and projected the proportion of dentists who might accept the Medicaid fees. The study indicated that the level of Medicaid dental reimbursement in 1999, nationally and in most States, was about equal to or less than the dental fees normally charged by the lowest 10th percent of dentists (the 10th percentile of respective fees) – i.e., 90 percent of dentists charged more, and usually substantially more, than the Medicaid fee.

Comparisons of Medicaid “UCR” and Additional Discounts with Fee Percentiles



Using Percentile Analysis to Establish Marketplace-based Medicaid Reimbursement Rates

Fee percentiles provide a way of representing the distribution of fees charged by dentists in a particular area, and are viewed as a useful basis for comparing state-specific Medicaid fees for selected procedures with fees that prevail in various markets for dental services. For example, the 10th percentile fee level for a particular area would indicate that 10% of dentists in that area charged the corresponding amount or less for a particular service. Stated differently, the 10th percentile fee level would represent a payment level that would be viewed as equal to or greater than the fees charged by 10% of dentists in that area. On the other hand, 90% of dentists in that area would view the 10th percentile fee level as less than the amount that they routinely charge. Similarly, the 25th percentile of fees for a particular area would represent an amount that was equal to or greater than the fees routinely charged by 25% of area dentists; however, 75% of area dentists would see the 25th percentile fee level as less than their routine charges for a specific service, and so on.

The use of **fee percentiles** can be exceptionally helpful as a basis for estimating the number or proportion of dentists in the state who might participate in Medicaid, at selected Medicaid payment levels. States can use this form of analysis to adjust dental payments so that their programs are likely to enlist sufficient dental providers and assure prompt access equal to that experienced by the general public. To compare Medicaid reimbursement levels to fee percentiles in a state, one ideally needs to obtain current data sets that describe the percentile distribution of fees routinely charged by the state's dentists. Information on dentist/fee percentile distributions are available from commercial organizations, such as the Ingenix Corporation's Prevailing Healthcare Charges System, or from other actuarially sound state-specific sources, such as those which may be available from commercial dental insurers. The American Dental Association's (ADA) Survey of Dental Fees, which offers regional rather than state-level fee distribution data, also has proven in the past to be an excellent source of information, if state-specific prevailing fee data are otherwise unavailable. (As noted previously, existing Medicaid claims data bases are not a good source for making dental fee comparisons).

Establishing Market-based Medicaid Reimbursement Rates

Beginning in the late 1990s, following a series of Oral Health Policy Academies organized by the National Governors Association with support from the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC), several states moved to increase Medicaid reimbursement rates to considerably higher levels consistent with the market-based approach presented here. While the extent of the impact of these reimbursement rate increases on access and utilization of services remains to be fully assessed, preliminary evaluations suggest, as noted by the GAO, that Medicaid payments that approximate prevailing private sector market fees do result in increased dentist participation in Medicaid. Examples are shown in the table below.

STATE	Adjustment to Medicaid Rates (Market Benchmarks)	Change in Dentist Participation	Interval Since Rate Increase (months)
Alabama	100% of Blue Cross rates	+39% +117%	24 44
Delaware	85% of each dentist's submitted charges	1 private dentist to 130 (of 378 licensed dentists)	48
Georgia	75th percentile of dentists' fees	+546% +825%	27 48
Indiana	75th percentile	+58%	54
Michigan Healthy Kids Dental	100% of Delta Dental Premier (16 counties)	+300%	12
South Carolina	75th percentile	+73% +88%	36 42
Tennessee	75th percentile	+81%	20

The table below shows data obtained from CMS 416 reports which illustrate increases in utilization of EPSDT dental services in five states subsequent to the rate increases noted above.

	FY1998 CMS 416 % with Dental Visits	FY2001 CMS 416 % with Dental Visits	2001 vs. 1998 CMS 416 % with Dental Visits	FY2003 CMS 416 % with Dental Visits	2003 vs. 1998 CMS 416 % with Dental Visits
AL	41,659	105,522	253%	151,581	364%
DE	8,428	15,430	183%	18,269	217%
IN	47,730	160,627	337%	212,909	446%
SC	96,590	88,523	92%	245,297	254%
TN	148,028	141,140	95%	249,252	168%

The table below provides a comparison of Connecticut Medicaid payment rates for selected procedures and fees charged by dentists within the North East Region (CT, MA, ME, NH, RI, VT) and the State of Connecticut. Details of the data elements are summarized below. The first two columns in the above table list procedure codes and descriptors for 15 procedures commonly used to assess Medicaid reimbursement rates for EPSDT services. The third column shows CT Medicaid payment rates in 2004 (which were largely unchanged since 1993 and have remained unchanged through 2007). The next two columns show the median or 50th percentile charges for these services by dentists in the six states in the New England region and in CT; while the second column from the right shows charges representing the 75th percentile of fees charged by dentists in CT. The far-right column shows the percentile equivalents for the CT Medicaid rates (i.e., the percent of dentists who charge the same or lower amounts than Medicaid paid). For example, the table indicates that for a periodic oral examination, the regional and CT 50th percentiles of dentists' charges were \$31 and \$37, respectively. The Connecticut Medicaid program paid \$18.08 for that procedure, an amount that 2% of dentists CT would see as equal to or greater than their current charges (i.e., the 2nd percentile). Alternatively, 98% of dentists in CT would see the Medicaid payment rate as less than their usual charges. Of particular note, for 9 of the 15 selected procedures, the respective Connecticut Medicaid payment amounts are less than the usual charges reported for any dentist in

CT. (i.e., less than the 1st percentile). From an economic perspective, these payment levels are substantially below the prevailing charges of the vast majority of CT dentists and would not be expected to provide adequate incentives for dentists to participate in Medicaid.

CT Medicaid Payment Rates for Selected Procedures			Comparisons with Dentists' Charges for Insured Patients in the ADA New England (NE) Region and in the State of Connecticut			
CDT4 Procedure Code	Procedure Description	CT Medicaid Payment Rate	NE Region 50th Percentile	CT State 50th Percentile	CT State 75th Percentile	State Percentile Corresponding to CT Medicaid Payment Rate
Diagnostic						
D0120	Periodic Oral Exam	\$18.08	\$31.00	\$37.00	\$39.00	2nd
D0150	Comprehensive Oral Exam	\$23.64	\$60.00	\$65.00	\$70.00	3rd
D0210	Complete X-rays, with Bitewings	\$45.00	\$100.00	\$109.00	\$110.00	< 1st
D0272	Bitewing X-rays - 2 Films	\$15.91	\$33.00	\$36.00	\$38.00	7th
D0390	Panoramic X-ray Film	\$35.00	\$68.00	\$65.00	\$100.00	< 1st
Preventive						
D1120	Prophylaxis (cleaning)	\$21.70	\$48.00	\$48.00	\$50.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	\$15.15	\$27.00	\$30.00	\$32.00	4th
D1351	Dental Sealant	\$17.75	\$40.00	\$40.00	\$44.00	< 1st
Restorative						
D0150	Amalgam, 2 Surfaces, Permanent Tooth	\$37.64	\$110.00	\$115.00	\$125.00	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	\$46.20	\$125.00	\$132.00	\$150.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	\$329.48				xx
D2930	Prefabricated Steel Crown, Primary Tooth	\$65.01	\$198.00	\$222.00	\$245.00	< 1st
Endodontics						
D3220	Removal of Tooth Pulp	\$45.46	\$114.00	\$120.00	\$150.00	< 1st
D3310	Anterior Endodontic Therapy	\$200.01	\$630.00	\$650.00	\$650.00	< 1st
Oral Surgery						
D7140	Extraction, Single Tooth	\$33.12	\$105.00	\$108.00	\$120.00	< 1st

Addressing financing and reimbursement issues is critical to engaging a sufficient number of dentists to provide adequate access to Medicaid dental services. However other important issues including, but not limited to, program administration, outreach and education of beneficiaries, and establishing effective communications among program administrators and providers also need to be addressed, applying lessons learned from Medicaid or commercial benefits models in order to make Medicaid dental programs function effectively.

3. Comment on CMS's Redaction of the Section on Policy Guidance Relating to Provider Reimbursement and Managed Care Oversight That You Wrote for the Guide to Children's Dental Care in Medicaid

The entire section of the document that AAPD submitted to HCFA (CMS) on Program Financing and Payments (Section C in the submitted table of contents) was deleted from the published version of the Guide. Topics addressed within this section are delineated below.

C. Program Financing and Payments

1. Funding Levels for Public Dental Programs for Children	22
2. Actuarial Estimates of Necessary Funding Levels for Publicly-Financed Children's Dental Benefits Programs	23
a. American Academy of Pediatrics Analysis	23
b. Reforming States Group Analysis	23
3. Historic Funding Levels in Public Pediatric Dental Care Programs	24
4. Reimbursement for Dental Services	24
a. U.S. General Accounting Office Study	25
b. Comparisons of Medicaid Reimbursement Rates for Pediatric Dental Services to Prevailing Market Rates	25
c. Global vs Selective Reimbursement Rate Adjustments	27
d. Periodic Reimbursement Rate Adjustments	27
5. General Financing Considerations for Medicaid/EPSDT Dental Program Improvements	28

The original material related to these topics has been summarized in abbreviated form in the section of this testimony concerning reimbursement rates and access to dental care for Medicaid children (# 2 above). Additional information was provided on comparisons of Medicaid dental expenditures vs. expenditure levels for the general population of U.S. children, along with summaries of relevant actuarial studies that had been conducted on behalf of the American Academy of Pediatrics and the Milbank Memorial Fund. These analyses showed that roughly \$14-\$17 (in 1998-1999 dollars) per enrolled beneficiary (often referred to as PMPM or per-member-per-month) would be necessary to pay for dental services for children enrolled in Medicaid at market rates comparable to those used by commercial dental benefit plans for employer-sponsored groups. Typical benefits administration rates would raise those levels to \$17-\$20 PMPM for administering a Medicaid dental benefits program -- i.e., if states were to contract with dental benefits managers to administer the benefits. A subsequent actuarial analysis commissioned by the American Academy of Pediatric Dentistry generally affirmed those findings. This information was included to provide a guide or benchmarks that state Medicaid programs could use to assess their current allocation levels for dental benefits for children enrolled in Medicaid. Available information suggests that many states allocate only a small fraction of the financial resources suggested by these actuarial studies (e.g., on the order of \$5-\$7 PMPM).

Other sections that were included in the version of the Guide that AAPD submitted to HCFA (CMS) but not included in the final version included information on a number of topics that have potential relevance to program administration, including issues for managed care arrangements:

- Legislative and Regulatory Requirements
- Basic Program Requirements;
- Screenings and Referrals for Diagnosis and Treatment;
- Reimbursement for Behavior Management;
- Integration of Dental Services and EPSDT Screening Services;
- Continuity of Care and Case Management;
- Contracts Development and Enforcement.

Two appendixes also were not included in the final published version of the Guide. The two appendixes included information on the AAP/Towers Perrin Actuarial Estimates and a document developed by a joint HCFA-HRSA-supported Maternal and Child Health Technical Advisory Group on "Policy Issues in the Delivery of Dental Services to Medicaid Children and their Families." A copy of the submitted version of the Guide has been provided to staff of the Subcommittee.

These sections were included in the version submitted by AAPD because, at the time, information on these topics, as well as differences between how medical and dental benefits are organized and financed, were not well known or understood by state policy makers, especially those who are not dental health professionals. This information could have helped state officials understand important aspects of the dental care delivery system and how it relates to Medicaid policies, especially in the absence of regulations corresponding to changes made in OBRA '89.

Mr. KUCINICH. I thank the gentleman.
Dr. Edelstein, thank you. Proceed.

STATEMENT OF DR. BURTON EDELSTEIN

Dr. EDELSTEIN. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to address the issue of children's dental services in Medicaid.

In my role now as a professor of health policy, I teach my students that public policymaking is that process that you folks exercise in allocating resources to competing interests, and we can't help but note how poorly dental tends to fare in that competitive arena. We observe that it not only fares poorly, but, objectively, it fares poorly in that only one in three children now is obtaining dental services in Medicaid, contrasted with nearly two in three in commercial coverage.

And, yes, I do appreciate that there has been a significant increase since so many of us committed so much effort, starting in 1998, to improve the proportion of children who do receive care in Medicare, but the assertion that it has come as a result of CMS action, that CMS has been able to expand dental services is one that I hope I will have an opportunity to discuss during the question period.

We also recognize that CMS has many options available to it to improve the situation, and I would suggest that there are three such options: exercising leadership, providing technical assistance, and holding States accountable to required performance.

When we look at dental care in Medicaid, my students and I can't help but notice how little, how infrequent, and how inadequate are those Federal efforts to ensure that children have the basic coverage that they need for their essential growth, health, and function. Most surprising has been the paucity of new action in this last year, given that it is almost now the first anniversary of Deamonte Driver's death.

As a consultant to the Department of Health and Human Services from 1998 to 2000, I came to know the dental Medicaid through a formal HRSA-CMS dental access initiative. Under the two prior national Medicaid directors, a 10-year vacancy in the CMS chief dental officer position was filled, and it was filled with a person who had direct reporting authority to the Medicaid director, a place that no longer is true; a joint technical advisory group [TAG], was formed; the regional office capacities to assist the States was bolstered; CMS and HRSA joined forces with the Governors Association and the National Conference of State Legislatures to work with the States; CMS funded demonstrations in prevention that proved that you could have better outcomes at lower costs; the Medicaid Guide was commissioned; the 416 Report was strengthened; States were required to report to CMS on their efforts. A variety of things were done and, as we now know, not one of these efforts was followed through in the last 7 years, until the recent announcement of the reinstitution of the TAG and the reinstitution of the focused reviews.

However, before coming to my consultancy with Government, I was a participating pediatric dentist, a clinician, and it was in that role that I personally came to understand this poisonous mix of low

payment and unnecessarily burdensome administration. Parents continue to struggle to find participating providers. Yet, my practice experience with another governmental program, the Tricare program for children who are military dependents, is very different, and it shows that when Government does seek to truly provide dental services, it can find a way.

Now, I understand that Medicaid kids are a different population than are the dependent children in the military, but the programs function so differently that I think it is telling about differences in priorities and commitments that the government has to these two different groups of children.

So, in brief, I would suggest there are three things that CMS could be doing now that would make a significant difference and continue to move us toward the two in three children receiving dental services instead of the one in three.

First, CMS could exercise definitive leadership. CMS could assure that the CMS staff, the staff in all of the regional offices, the State Medicaid directors all know that dental care is not only required under EPSDT, but is a priority of the administration. It could promote evidence-based early intervention that starts dental care well before the disease begins by focusing on that periodicity schedule from OBRA 1989 that never got moved. With little expenditure of time and money, CMS could partner with HRSA again, but also with CDC, ARQH, NIH, IHS, WIC, Head Start, private organizations, foundations, professional associations to really use its bully pulpit, its leadership, to leverage the capacities of others.

Second, CMS could provide meaningful technical assistance. CMS could provide intensive and extensive technical assistance, best practices, guidance, release of the Guide, release of the TAG findings from all those years ago, develop and disseminate model contracts, convene States again to learn from one another, ensure that there is a competent cadre of people in the regional offices who can really help the States, make suggestions about what can be done under HIFA and DRA to improve dental services. And when problems flare up, as they did in this last year in Georgia and now in Connecticut, CMS could be there to broker solutions and to provide technical assistance to the States.

Last, I would suggest that CMS could more substantially exercise meaningful oversight. CMS has clearly demonstrated its willingness and its capacity to act forcefully on a number of issues, including, for example, the August 17th stringent guidance on State program expansions. Why CMS has not acted as forcefully on dental issues is inexplicable unless one believes that even the death of a child does not sufficiently highlight the importance of basic dental care. A Federal directive to States that compliance with reporting and service requirements under the law is of serious import to the agency would go a long way.

So, taken together, I would suggest that leadership, technical assistance, and oversight could bring dental care to the forefront, it could honor Deamonte Driver's life, and it could assist the millions of children in Medicaid who currently have so little access to essential dental services. Thank you.

[The prepared statement of Dr. Edelstein follows:]

Testimony of Burton L. Edelstein DDS MPH

**Professor of Dentistry and Health Policy & Management
Columbia University**

**Chairman of the Board
Children's Dental Health Project**

on

**"One Year Later: Medicaid's Response to Systemic Problems Revealed by
the Death of Deamonte Driver"**

**before the
House Oversight and Government Reform
Subcommittee on Domestic Policy**

February 14, 2008

Mr. Chairman and Members of the Subcommittee,

I appreciate the opportunity to testify today about the federal government's roles and responsibilities in ensuring that children in Medicaid have access to the dental care that is promised to them by federal law. My name is Dr. Burton Edelstein. I am a professor of dentistry and health policy at Columbia University and serve as Board Chair of the Children's Dental Health Project, an independent non-profit organization committed to improving children's access to oral health.

In my role as a professor, I have taught my students that public policymaking is the process through which government prioritizes and allocates resources to competing interests. We observe that dental care has fared very poorly in this competition; that Medicaid grossly underfunds dental care; that only one-in-three covered children obtains dental services in a year; and that adult dental needs are often ignored altogether. Yet we also recognize that CMS has many options at its disposal to improve this situation by exercising leadership, providing technical assistance, and holding states accountable for required performance. When we look at dental care in Medicaid, we note how little, how infrequent, and how inadequate are federal efforts to ensure that children have at least access to basic dental services that are essential for growth, health, and function. Most surprising to us is the paucity of attention paid to dental Medicaid in the year following the death of Deamonte Driver – not because the incident was so extreme (as it surely was) but because it so blatantly highlighted the importance of the dental Medicaid program for children.

As a consultant to the Department of Health and Human Services from 1998 to 2000, I came to know dental Medicaid through a formal joint HRSA-CMS dental access initiative. Under the two national Medicaid Directors who preceded Mr. Smith, the 10-year vacant CMS chief dental officer position was filled and situated with direct access to the Medicaid Director. A joint-agency Technical Advisory Group, or TAG, was formed. DHHS Regional Office capacity was bolstered. CMS and HRSA joined forces with the governors and state legislators to encourage and assist states. CMS funded demonstrations that showed cost saving *and* better health outcomes. The Medicaid guide was commissioned. State 416 performance reporting was strengthened. And states were required to report to CMS on their efforts and plans to further improve dental care for children in Medicaid.

As we now know, not one of these efforts was continued into the current Administration and only now – seven years later – are the TAG and state investigations being re-initiated.

As a participating clinician, I have come to personally experience the difficulties facing practitioners who seek to treat socially vulnerable children—difficulties that arise from a poisonous mix of low-payment and unnecessarily burdensome administration. As a result, parents still struggle to find care for their children. Yet my practice's experience with another governmental dental insurance program for children, the Department of Defense's Tricare Dental Program, shows that government *can* make dental programs work. Twice the proportion of military dependent children in the well-funded and

managed Tricare program obtain dental care as do children in Medicaid. The contrast between these two programs is both stark and telling about priorities and commitments.

So what could CMS do? I would suggest three things ranked from the least to most demanding:

1. *Exercise leadership:* CMS, and particularly the Director of the Office of Medicaid Services, could ensure that CMS staff, the staff in all regional offices, and state Medicaid directors know that dental care is not only federally required by EPSDT but it is an explicit priority. It could promote evidence-based early intervention that starts dental care before the start of disease by age two and put the “E” for Early back into EPSDT. With little expenditure of time and money, CMS could again partner with HRSA, CDC, ARQH, IHS, NIH WIC, Head Start, foundations and others to leverage each others’ capacities, explore creative solutions, and prioritize dental care for children.
2. *Provide meaningful technical assistance:* CMS could provide intensive and extensive technical assistance to states – it could identify and promote best practices, issue guidance, release the complete Medicaid guide and TAG’s findings, develop and disseminate model contracts, convene states to learn from one another, ensure a competent and ready cadre of regional officials, and develop novel Medicaid solutions that are now available under the HIFA and DRA provisions. When problems arise in dental program—as happened most recently in Georgia and Connecticut—CMS could offer its immediate assistance. As a

start, its current “Medicaid Dental Coverage” website could be dramatically expanded, promoted, and enhanced.

3. *Exercise oversight:* CMS has clearly demonstrated its willingness and capacity to act forcefully when it desires to do so, as evidenced for example by the August 17th stringent guidance to states on program expansions. Why CMS has not acted forcefully on the dental crisis is inexplicable unless one believes that even the death of a child cannot highlight the importance of basic dental care. A federal directive to states that compliance with reporting and service requirements is mandatory would bring attention and action where it is sorely needed and would capitalize on past efforts that are now so sadly stalled.

Taken together, the exercise of leadership, technical assistance, and oversight could bring dental care to the fore, honor Deamonte Driver’s life, and assist the millions of children in Medicaid who currently have so little access to needed care.

Mr. KUCINICH. Thank you very much.

Before I begin with my questioning, did you have an opening statement? OK. All right. If you would like, you could submit one for the record at any time.

Mr. SHAYS. The only statement I would make, since you have invited that, is to thank our witnesses for coming and to thank you for having this hearing. This issue presented itself in a very shocking way and, frankly, I was stunned that—and I plead ignorance—that bad dental care could result in what it resulted in in the case of the young man, Mr. Driver.

Mr. KUCINICH. I thank my colleague.

A subcommittee investigation revealed that there are 10,780 Medicaid beneficiary United enrollee children in Maryland who have not received dental services in at least four consecutive years, so I would like to begin this discussion with Mr. Smith.

What is the total number of Medicaid beneficiary children, those that are enrolled in the Medicaid managed care organizations, in Maryland who have not received dental services in at least three consecutive years?

Mr. SMITH. Mr. Chairman, we don't have the data at this point to be able to track individuals. The data that comes to us on the 416, for example, is dated that is in the aggregate. To track specific individuals, the States have that information; they are the ones that process the claims, etc. But under our current data collection systems and the capacity that we have, we don't track individual claims.

Mr. KUCINICH. Do you think it would be helpful if—for example, do you have anybody on your staff that would pick up a phone and say, hello Maryland, what is the total number of Medicaid beneficiary children who haven't received dental services? Do you ever do that? Do you collect data in that way? Do you do it informally if the formal systems aren't working?

Mr. SMITH. Mr. Chairman, our lack of data collection is a great frustration to me. Yes, we can—and oftentimes, unfortunately, that is what we end up doing, responding to all types of requests for data, but that is what we are left with, is picking up the phone, calling, oftentimes—and, again, even in the 416. The 416 we still have five States outstanding to where we don't have two States still have not even submitted the data yet from 2006. The other three States we are not satisfied that they are reporting accurately. So accurate reporting and our data systems, although I believe we have great improvement over previous years, we are still a long ways from what is satisfactory.

Mr. KUCINICH. I understand your frustration. I want to point something out, that our staff actually contacted Maryland and found out that approximately 22,555 children ages 5 to 14 have not received care in three consecutive years, and the numbers would be even greater if we considered the CMS 416 standards, which are children ages 4 to 20; it widens out the age groups.

I would just like to submit to you that as a Federal administrator, in addition to whatever data base issues exist here, it might be helpful if you could find a way for your own staff to be able to access the kind of information that a relatively small congressional staff has been able to get. It occurs that during your EPSDT review

in Maryland, you may have been able to find that out, and I just want to point out that another way of getting this information is by asking the Medicaid managed care organizations.

As part of our investigation of United, my staff asked them how many of their beneficiary children had not seen a dentist in 1, 2, 3, 4, 5 consecutive years, and we have a letter somewhere that I want to enter into the record by unanimous consent. As I mentioned earlier, there are nearly 11,000 children enrolled in United that have not seen a dentist in 4 consecutive years, putting them in the same position that Deamonte was when he died. So, without objection, this will go into the record.

[The information referred to follows:]

HENRY A. WAXMANN, CALIFORNIA
CHAIRMAN

TOM LANTOS, CALIFORNIA
EDOLPHUS TOWNS, NEW YORK
PAUL E. KANJORSKI, PENNSYLVANIA
CAROLYN B. MALONEY, NEW YORK
ELIJAH E. CUMMINGS, MARYLAND
DENNIS J. KUCINICH, OHIO
DANNY K. DAVIS, ILLINOIS
JOHN F. TERRELL, MASSACHUSETTS
WM. LACY CLAY, MISSOURI
DANIE E. WATSON, CALIFORNIA
STEPHEN F. LYNCH, MASSACHUSETTS
BRIAN WOODS, NEW YORK
JOHN A. YARMOUTH, KENTUCKY
BRUCE L. BRALEY, IOWA
SEANDE HUGHES, KENTON
DISTRICT OF COLUMBIA
BETTY McCOLLUM, MINNESOTA
JIM COOPER, TENNESSEE
CHRIS VAN HOLLIN, MARYLAND
PAUL W. HODGE, NEW HAMPSHIRE
CHRISTOPHER S. MURPHY, CONNECTICUT
JOHN P. SARIBANIS, MARYLAND
PETER WELCH, VERMONT

ONE HUNDRED TENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6143

MAJORITY 202 225-2031

FACTFINDER 202 225-4784

MINORITY 202 225-5074

www.oversight.house.gov

October 2, 2007

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

DAN BURTON, INDIANA
CHRISTOPHER SHAYS, CONNECTICUT
JOHN M. McGLATH, NEW YORK
JOHN L. MICA, FLORIDA
MARK E. SOUDER, INDIANA
TODD RUSSELL PLATT, PENNSYLVANIA
CHRIS CANNON, UTAH
JOHN J. DUNCAN, JR., TENNESSEE
MICHAEL R. TURNER, OHIO
DARRELL E. ISSA, CALIFORNIA
KENNY MARCHANT, TEXAS
LYNN A. WESTMORLAND, GEORGIA
PATRICK T. McHENRY, NORTH CAROLINA
VIRGINIA FOUST, NORTH CAROLINA
BRYAN F. BLUMENTHAL, CALIFORNIA
BILL SALLI, IDAHO

Mr. Jonathan Dinesman
National Vice President
Government Relations & Regulatory Affairs
AmeriChoice, United HealthCare Group
8045 Leesburg Pike, 6th Floor
Vienna, VA 22182

Ms. Susan Tucker
Executive Director
Office of Health Services
Department of Health and Mental Hygiene
201 West Preston St.
Baltimore, Maryland 21201

Dear Mr. Dinesman and Ms. Tucker:

After the death of twelve-year old Deamonte Driver, who died of a brain infection caused by untreated tooth decay, the Domestic Policy Subcommittee began an investigation into the adequacy of access to dental care for Medicaid beneficiaries in the State of Maryland. On May 2nd we held a congressional hearing to examine the circumstances that led to Deamonte's death.

In preparation for the hearing, Majority staff evaluated the adequacy and reliability of United HealthCare Group's ("United") dental provider network in the form that Deamonte's family and their advocates had available to them. Staff found that United's dental provider network available online was virtually useless to parents and guardians. Our investigation showed that of the 24 general dentists in the United dental network in Prince George's County, only 15 of them were unduplicated, 3 would not return phone calls, 2 were fax numbers, 1 was a wrong number, 8 said they did not accept Medicaid, and the 1 dentist on the list who did accept Medicaid was an oral surgeon and not a general dentist.

Mr. Dinesman and Ms. Tucker
October 2, 2007
Page 2

United disputed the Subcommittee's findings in a Washington Post article in which the Company stated that it had a robust network of 92 dental providers in Prince George's County.¹ A United representative said, "We've got 92 dentists in Prince George's County and in 2006 we paid claims to 78 of them. I don't know where [Congressman Kucinich] is pulling that from."

The Subcommittee requested and evaluated documentation of United's dental network and records of the claims submitted for services rendered to United beneficiary children in 2006. The Majority staff's findings are as follows:

1. Deamonte Driver was one of over 10,780 Medicaid eligible children in Maryland who had not seen a dentist in four or more consecutive years.

At the time of his death, Deamonte Driver had not been seen by a dentist for four consecutive years. Upon reviewing United's records, the Subcommittee discovered a significant problem of chronic underutilization among the company's enrollees. According to United's records, 10,780 Medicaid-eligible children enrolled with United had not seen a dentist in four or more consecutive years. Another 22,110 children had not received dental care in at least two years. The lack of dental visits proved fatal in Deamonte's case. The prevalence of thousands of similarly situated children throughout Maryland is cause for concern.

2. Only 7 dentists provided 55% of total services to United beneficiaries in Prince George's County.

United's encounter data of dental visits made and treatments completed in Prince George's County for the calendar year 2006 revealed that only seven providers represent 55% of all of the 18,085 claims received.

3. Only 3 dentists at a single practice provided 35% of total services to United beneficiaries and received 41% of all payments made by United to dental providers in Prince George's County.

The encounter data also showed that of the seven most active dentists, three provided 35% of total services, or 6,182 claims. Those three dentists share a single practice located in two offices in Prince George's County. The amount paid to their offices represents 41% of all payments made by United to Medicaid dental providers, or \$876,758. The dental practice would have to serve approximately 60 children a day in order to submit 6,182 claims in 2006. The Subcommittee is alarmed that a single dental

¹ Otto, Mary, "Death of Maryland child explores dearth of dental care," Washington Post, May 3, 2007.

Mr. Dinesman and Ms. Tucker
 October 2, 2007
 Page 3

practice comprised of 3 dentists, is bearing the weight of Prince George's County dental needs.

4. Nineteen (19) dentists listed in United's dental network provided zero services to eligible children in Prince George's County.

According to United's encounter data of dental services rendered in 2006, 19 of the dentists included in its dental network provided zero services to Medicaid beneficiaries.

5. Twenty-two (22) dentists listed by United provided services to only one child merely a single time and 45 dentists cared for eligible children less than 10 times in Prince George's County.

According to the encounter data provided by United, 22 dentists saw only one United beneficiary a single time the entire year of 2006. In the same year, an additional 23 dentists cared for a United-enrolled beneficiary child more than once and fewer than 10 times.

6. Seven (7) dentists were unreachable by phone.

The Subcommittee called the entire list of Prince George's County dentists provided by United. Seven (7) dentists could not be reached by telephone. They were unreachable for a number of reasons: because the number listed was disconnected; the dentist listed had left the dental office; or the wait time for a representative was abnormally long. Of those listed dentists that answered the telephone, 14 stated that they "never took Medicaid." During a second round of calls, several of the 14 offices indicated that they did indeed accept Medicaid but no longer do so. Some of those dentists who reported that they no longer accept Medicaid continue to offer services to their pre-existing Medicaid patients. One of the offices stated that it not only refuses United's Medicaid but that it also does not accept United's PPO.²

7. Twenty (20) dentists asserted by United to be in the network were later excluded by United in their response to the Committee's inquiry.

² The methodology used to conduct this verification process: the caller first asked, "Does your office accept Medicaid?" Irrespective of the answer, the caller then asked, "Does your office accept AmeriChoice or United HealthCare's Medicaid?" If the response was "yes" the questioning stopped, if the response was "no," the caller asked a final question, "Does your office accept United HealthCare's PPO?" After completing the first round of calls, the caller made a second round of calls to the offices that answered "no" to the first and/or second questions for clarification purposes.

Mr. Dinesman and Ms. Tucker
October 2, 2007
Page 4

In response to the Subcommittee's request³ for a complete list of United's dentists in Prince George's County, United amended its assertion made to the Post and indicated that only 72 of the 92 dentists it previously reported are participating in United's Medicaid dental provider network.

8. United changed its web site after Congress began its inquiry.

The Subcommittee majority staff's investigation into United's dental network was originally conducted in April 2007. At that time only one searchable database existed on United's Medicaid dental directory.⁴ Clicking on "Specialty type" and selecting "General Dentistry" in "Prince George's County" yielded the 24 results on which the Subcommittee's findings were based.

Shortly after the Subcommittee's May 2nd hearing, United added another link to its Medicaid dental directory.⁵ This directory belongs to Dental Benefit Providers which is a wholly-owned subsidiary of United. Dental Benefit Providers (DBP) provides private label dental benefits to health plans and insurance companies and presently services fourteen other health plan and/or insurance companies nationally in addition to United.⁶ Despite this progress, the Subcommittee remains concerned that neither United nor the Maryland Department of Health and Mental Hygiene ("DHMH") had addressed that obvious negligence before the hearing.

The Subcommittee staff's investigation into the adequacy of access to dental care for Medicaid eligible children in Maryland raises serious questions about the quality of United's network of providers and the reliability of the lists the company publishes for use by its enrollees. The Subcommittee Majority staff's experience indicates the real difficulties parents and guardians experience in identifying a general dentist to serve Medicaid beneficiary children. Calling the dental offices United listed is a hit-or-miss exercise. Few of its dentists are consistent providers, and finding them is difficult.

The Subcommittee would like to know what United and DHMH plan to do to address each of the issues raised in this letter. Please include a timetable detailing the execution of these plans.

³ Document request sent to United HealthCare dated May 4, 2007.

⁴ See http://www.uhcmedicaid.com/find_doctor/first.jsp?xplan=uhcmed&xtitle=Doctor.

⁵ See <https://www.myuhcdental.com/presence/release/memberfaq.asp> and https://www.myuhcdental.com/presence/release/MemberLocateDentist.asp?nwgp_id=NG0000000003.

⁶ See https://www.dbp.com/presence/release/aboutdbp_overview.asp.

Mr. Dinesman and Ms. Tucker
October 2, 2007
Page 5

The Subcommittee requests your response to these findings and its request for your response plan no later than 5 PM on Friday October 19, 2007.

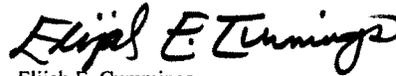
The Committee on Oversight and Government Reform is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X.

If you have any question regarding this request, please contact Noura Erakat of the Subcommittee staff at (202) 226-5867.

Sincerely,



Dennis J. Kucinich
Chairman
Subcommittee on Domestic Policy



Elijah E. Cummings
Member of Congress

cc: Darrell Issa
Ranking Minority Member

cc: Dennis Smith
Director, Center for Medicaid and State Operations

Mr. KUCINICH. Now, in addition to Maryland, there were 14 States that had less than a 30 percent utilization rate in 2001. They reported their utilization rates in response to the January 18, 2001 State Medicaid letter, and I just wondered if you could help us and tell us, in each of these States, what is the total number of Medicaid-eligible children that have not received dental services in at least three or four consecutive years, if you have any of this information. I am going to go over a list, and just tell me if you have any information. If you don't, we would like you to get it. We think these figures exist. We are looking for Alabama. Do you have that?

Mr. SMITH. Mr. Chairman, I don't have—as I responded earlier, we have data in the aggregate. We can go back to the States that you would like to—

Mr. KUCINICH. OK, our staff is going to provide you with a list. I didn't invite you here to embarrass you, I just want to point out that we have some difficulties that exist, I think, that perhaps are impediments to the efficient management at a Federal level to permit higher rates of utilization. I am going to ask staff to present this list.

OK we have correspondence from Maryland, North Carolina, and from CMS that we are going to put into the record with unanimous consent.

[The information referred to follows:]

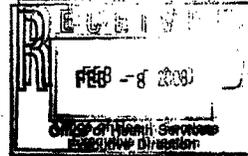


STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
 201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

February 8, 2008



The Honorable Dennis J. Kucinich, Chairman
 Subcommittee on Domestic Policy
 Committee on Oversight and Government Reform
 House of Representatives
 2157 Rayburn House Office Building
 Washington, DC 20515-6143

Dear Chairman Kucinich:

In preparation for the February 14, 2008 follow-up hearing by the Subcommittee on Domestic Policy on access to dental services for low-income children, my staff received a request for an update on actions taken by Maryland since the tragic death of Deamonte Driver. I will include information on the recommendations of the Dental Action Committee and then describe the Governor's 2008 budget request to addressing this problem.

One of my first priorities as Secretary of the Department of Health and Mental Hygiene has been to address dental access issues for low-income children in the State of Maryland. In June 2007, I appointed a Dental Action Committee to develop recommendations for improving access to dental services for all low-income children. On September 11, 2007, the Committee made 60 recommendations with a goal of establishing Maryland as a national model for children's oral health care. One of their recommendations was to hire a State Dental Director. I am pleased to let you know that Dr. Harry Goodman returned to the Department of Health and Mental Hygiene as our full-time dental director earlier this month.

After carefully reviewing the DAC recommendations and meeting with the Governor and the Secretary of the Department of Budget Management, I am pleased to announce that we are moving forward with the following major recommendations. Our ultimate goal will be to ensure that all children in Maryland have a dental home.

The Honorable Dennis J. Kucinich
February 8, 2008
Page Two

1. DHMH will move as quickly as possible to develop and issue a request for proposals (RFP) for a single statewide vendor to coordinate and administer dental benefits for Maryland Medicaid beneficiaries. This recommendation will require the Department to carve dental services out of the Managed Care Organization (MCO) service package under the HealthChoice Program and have them administered through a single Administrative Services Organization.
2. The Governor's budget (\$14M with state and federal match) includes the first installment of a three-year effort to bring Maryland Medicaid dental rates up to the 50th percentile of the American Dental Association's South Atlantic region charges. This multi-year initiative is crucial in attracting additional providers.
3. The Governor's budget (\$2.05M) included new funds to enhance the dental public health infrastructure. These funds will help establish two dental public health clinics in local health departments and provide an increase in operational support for existing local health department dental clinics thereby increasing access to oral health services for low-income children. In addition, this enhanced funding will allow the Office of Oral Health to provide expertise to local health departments as they construct these clinics and implement oral health programs. Multi-year funding will be necessary to ensure the success of these and other local health department dental clinics and to build additional dental health clinics in underserved areas of the State.
4. The Dental Action Committee also made a dental scope of practice recommendation that likely requires legislation creating a new "public health dental hygienist" category which would enhance dental hygienists working in public health facilities to provide needed dental screening and preventive services for low-income populations. We stand ready to work with the Legislature on this and similar issues.
5. The Department plans to seek federal funding to develop a unified and culturally appropriate oral health message. A well-developed campaign can be shared with other State Medicaid programs.

The Honorable Dennis J. Kucinich
February 8, 2008
Page Three

Committee staff also asked me to comment on whether the Department has worked with the Centers for Medicare and Medicaid Services on these initiatives. The Department has communicated our initiatives to CMS throughout the fall of 2007. On October 5, 2007, CMS sent the Department a letter asking for an explanation of actions we had taken or planned to improve access to oral health care services for Maryland Medicaid beneficiaries. We responded in detail to that request on October 15, 2007. On October 18, 2007, CMS sent a team to conduct a Maryland EPSDT Review which focused on dental services. The State received a draft report regarding this site visit on November 28, 2007. We responded to this report and also took the opportunity to correct misconceptions and misunderstandings that arose during the EPSDT on-site review. During November of 2007, CMS sent a letter to the Department asking for additional information concerning the UnitedHealth Group dental provider network. CMS also asked for assurances that Maryland had not paid for services that were not delivered and questioned whether there was a need to sanction UnitedHealth Group. The State responded to this letter in November 2007. We subsequently received a letter from CMS on December 11, 2007.

We all have been affected by the death of Deamonte Driver. Every effort will be made to ensure that all Maryland children, regardless of race, ethnicity or economic status, will have a dental home. It is my strong belief that implementing these multi-year initiatives will result in Maryland becoming a model for the country in increasing access to oral health for our children.

Sincerely,



John M. Colmers
Secretary

cc: The Honorable Martin O'Malley
Alice Burton
Arlene Stephenson
John Folkemer
Russell W. Moy, M.D., M.P.H.
Susan J. Tucker
Harold S. Goodman, D.M.D., M.P.H.



North Carolina Department of Health and Human Services
 Division of Medical Assistance
 Dental Program

2501 Mail Service Center • Raleigh, N. C. 27699-2501

Michael F. Easley, Governor
 Dempsey Baston, Secretary

William W. Lawrence, Jr., M.D., Acting Director

February 11, 2008

Honorable Dennis J. Kucinich
 Chairman
 Domestic Policy Subcommittee
 U.S. House of Representatives
 Washington, D.C. 20515

Dear Chairman Kucinich:

Up to 80 percent of low-income children enter kindergarten in North Carolina having experienced tooth decay. Their oral health and quality of life are further compromised because of extremely difficult challenges in gaining access to dental care. A number of organizations in North Carolina have been involved over the last decade in aggressively and collaboratively trying to help resolve these problems through prevention and treatment programs. Our overall strategy was outlined in a 1999 report to the NC General Assembly by the NC Institute of Medicine (<http://www.nciom.org/projects/dental/dental.html>). One centerpiece of our strategy is a Medicaid Initiative in which children birth to 3 years of age receive preventive dental services in primary care medical offices. The purpose of this letter is to briefly provide the background for this program, its impact on young children and their families and the contributions that Federal funding, including CMS provided to its development.

The Medicaid program, known as Into the Mouths of Babies (IMB), began after a successful demonstration in a few counties in the Appalachian region of the state and pilot studies in an expanded number of medical offices statewide. The program was expanded statewide in 2001. The goals of the IMB program are to: (1) increase access to preventive dental care for low-income children 0 to 3 years of age; (2) reduce the prevalence of early childhood caries (ECC) in low-income children; and (3) reduce the burden of treatment needs on a dental care system stretched beyond its capacity to serve young children. Primary care medical providers are reimbursed for screening and risk assessments for oral problems, counseling of parents about oral health and application of fluoride varnish to the teeth of children. Physicians can provide these services in up to six visits before the child is 42 months old. Providers participate in a Continuing Medical Education program, and, to date, more than 3,000 pediatricians, family physicians, nurses and other types of healthcare professionals have been trained. In the third quarter of 2007 alone, the most recent quarter for which information is available, more than 28,000 visits occurred in medical offices in which these oral health services were provided.

Because of its innovation and potentially large impact on the oral health of young children, an extensive evaluation of IMB was undertaken. Some details and current status of the evaluation are provided in the attached Research Brief. To summarize briefly, the program has led to a substantial increase of about 30-fold in access to preventive services for infants and toddlers enrolled in Medicaid. The IMB research team has gathered evidence demonstrating that those children who received preventive services in medical offices need fewer dental treatment

services than infants and toddlers who have not received IMB services. In addition, IMB has led to an increase in access to treatment services through what we assume to be the effect of referral of children who already have disease at the time of the physician visit to the dental care system. Taken together, these findings suggest that the IMB program both prevents early occurrence of dental disease and promotes earlier entry into the dental care system for those in greatest need.

Federal funding played a very important role in the success of the IMB program. Partial funding for the initial developmental work was provided by the Appalachian Regional Commission [ARC Project No. NC-13186-00] for a project entitled "Dental Health Promotion among Preschool Children in North Carolina's Appalachian Region: Smart Smiles Fluoride Varnish Project". The five-year demonstration was initially funded by the Centers for Medicare and Medicaid Services (CMS) and was later supported by funding from the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC) for the project entitled "Development and Evaluation of a Medical Model for Early Childhood Caries" [Grant No. 11-P-91251/4-02]. This application for statewide implementation of the IMB project was developed in response to a request for applications from several agencies in the U.S. Department of Health and Human Services (DHHS) in May 2000. The request (Catalogue of Federal Domestic Assistance Program Number 93.779) sought applications "to identify methods of innovative management of oral conditions among young children enrolled in Medicaid and SCHIP that result in oral health improvements and dental care cost savings." This funding allowed Medicaid and partners in North Carolina to further develop our innovative approach to the prevention of early childhood caries in children enrolled in public insurance programs in North Carolina. In particular, the funding provided for staff to develop the curriculum for training, conduct the training and generally oversee the substantive aspects of the program and generate the science supporting the innovative program.

In our opinion, this one-time funding initiative from CMS and other Federal Agencies provides an excellent model for one strategy that the Federal government could use to stimulate innovative thinking about new approaches for addressing the long-standing problems that children in this country face in gaining reasonable access to dental care. The partners in the IMB collaborative believe that renewal of this funding program, first implemented in 2000 to support innovative demonstration programs, would result in new approaches beyond the medical model developed in North Carolina that would yield oral health benefits to children enrolled in public insurance nationwide.

Please feel free to contact me with additional requests for information that you might have about IMB. I would like to thank you on behalf of all of the partners in the IMB program for bringing well-deserved attention to this important North Carolina dental public health initiative.

Sincerely,

Mark W. Casey DDS, MAH

Mark W. Casey, DDS, MPH
Dental Director
NC Division of Medical Assistance


 THE UNIVERSITY
 of NORTH CAROLINA
 at CHAPEL HILL

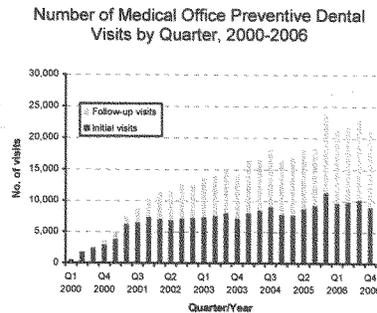
Research Brief:
Evaluation of Into the Mouths of Babes Program

R. Gary Rozier, DDS, Sally C. Stearns, PhD,
 Bhavna T. Pahel, BDS, Rocío B. Quinonez, DDS

June 2007

This Research Brief summarizes key findings from an analysis of Medicaid claims and enrollment data from January 2000 through June 2003 done to evaluate the impacts of the *Into the Mouths of Babes* (IMB) program on access to dental care by Medicaid-enrolled children.¹ Findings presented here build on previous studies of medical providers and patients in which we have reported that (1) IMB is easily integrated into busy medical practices after the enhanced CME provided originally by the NC Academy of Family Physicians and the NC Pediatric Society, and currently being provided by the Oral Health Section; (2) parents are very satisfied with these services; and (3) these positive features of the program result in widespread implementation across the state.

The IMB program was approved for statewide implementation beginning in January 2000, with training and participation of practices increasing over the next several years. By 2006, the number of visits had steadily grown to more than 80,000 visits (See Figure). In June 2003, the last month included in this analysis, providers in 277 medical offices and public clinics in 86 of North Carolina's 100 counties had been trained and were providing services. These preliminary results therefore pertain to the implementation phase of the program. All analyses are based on observational data rather than a randomized trial and are therefore subject to concerns about possible selection biases that may accompany observational studies.



Effect of the IMB Program on Access to Preventive Dental Care: The IMB program has led to a substantial increase in access to preventive dental services by enabling Medicaid children younger than 3 years of age to receive dental screening, counseling and fluoride varnish in physicians' offices. By 2002, fewer than one out of every 1,000 children 12 through 23 months of age enrolled in Medicaid had a preventive visit in a dentists' office compared to 145 with one or more IMB visits in a medical office. Out of 1,000 children age 24 through 35 months, 5 had a preventive visit in a dentist office compared to 86 with one or more IMB visits in a medical office. Although the IMB program has therefore substantially increased access to preventive dental care in North Carolina, a large proportion of young children still are not receiving preventive dental care in a given year; albeit the IMB program was still being implemented during the period of time under study. No reduction in use of dentists for preventive care was detected for children up to age 3, indicating that the IMB program supplemented rather than displaced existing levels of preventive dental care. Even in this early implementation phase of IMB, children from every

School of Public Health
 Department of Health Policy and Administration
 1101 McGavran-Greenberg Hall
 Campus Box, 7411
 Chapel Hill, NC 27599-7411

county in NC were using these services. The program extended preventive dental services to as many as one-third of the state's counties where no child of this age received any preventive dental care in dental offices before implementation of the program.

Effect of the IMB Program on Access to Restorative Dental Care: The implementation phase analysis showed a statistically significant increase in use of dental restorative services for young children. For example, out of 1,000 children aged 24 months, we estimate that 6.8 children would have received restorative dental treatment in the absence of IMB but 7.3 children received restorative treatment after implementation of IMB. This increase likely occurred for two reasons. First, many of the children receiving IMB services during the implementation phase did not receive preventive services at an early age, i.e., they did not have timely preventive dental care from the time of initial tooth eruption, and consequently the IMB program did not have the opportunity to prevent the dental disease that developed in these children. Second, we believe that providers trained under the IMB program detected existing disease at the time of the preventive visit and, in many cases, helped to facilitate referrals to dentists for timely treatment of that disease. The increase in restorative dental services represents an improvement in the dental health of Medicaid children and therefore is another important outcome of the program.

Effectiveness of the IMB Program in Ultimately Reducing Need for Dental Treatment: To assess the potential of IMB in ultimately reducing dental disease among young children, we conducted additional analyses comparing dental outcomes for children who received at least four IMB visits and were eligible for Medicaid at 6 months of age to children who never received IMB services. These analyses showed a statistically significant reduction in restorative treatments for anterior teeth that increased with age. By four years of age, the estimated cumulative reduction in the number of restorative treatments was 39% for anterior teeth. (A 12% reduction in restorative treatments for posterior teeth was not statistically significant.) The sample size did not allow an analysis beyond age four, and the sample of children available for analysis at this age was extremely small.

Cost-effectiveness of the IMB Program: Because the costs of increasing access to preventive dental care are not offset (at least as currently estimated) by reductions in restorative treatment costs, the IMB program was not cost-saving to Medicaid during the implementation phase. However, access to care and dental health were both improved by the program. We have deferred an analysis of cost-effectiveness of the program until we can increase the size of the sample receiving greater exposure to IMB services (i.e., four or more visits) and use estimates of benefits in terms of reduced need for dental treatment up to age seven years.

Ongoing Research Activities: Additional Medicaid files through 2006 are being used to provide further assessments of these evaluation questions beyond the implementation phase. In particular, we will assess the extent to which the IMB program results in better access to preventive and restorative care as well as cost-effectiveness and cost implications for the Medicaid program.

¹ Funding for evaluation of IMB was provided by the Centers for Medicare and Medicaid Services, Health Resources and Services Administration, and the Centers for Disease Control and Prevention. The IMB demonstration program was carried out through a collaborative partnership of the North Carolina Academy of Family Physicians, INC, the North Carolina Pediatric Society, the Oral Health Section of the Division of Public Health, Division of Medical Assistance and the Schools of Dentistry and Public Health of the University of North Carolina at Chapel Hill.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

Honorable Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee
U. S. House of Representatives
Washington, D. C. 20515

Dear Chairman Kucinich:

In my November testimony before the Committee on Oversight and Government Reform, I assured you that I would share the results of our on-site review of Maryland's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. We have sent our final report to the state and I am enclosing a copy for you. The Report includes several recommendations and we will conduct a follow-up review later this year to ensure that the state has taken the necessary steps to implement the recommendations.

I also look forward to appearing before the Subcommittee again next week. Thank you for your continued interest in this important matter.

Sincerely,

A handwritten signature in cursive script that reads "Dennis G. Smith".

Dennis G. Smith
Director

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499



Region III/Division of Medicaid and Children's Health Operations

FEB 5 2008

John G. Folkemer
Deputy Secretary
Health Care Financing
MD Department of Health and Mental Hygiene
201 West Preston Street, Suite 525
Baltimore, MD 21201

Dear Mr. Folkemer:

Please find enclosed the final report on our October 18, 2007 review of Maryland's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, with a focus on dental services for children. We have taken into consideration your feedback which you sent to us in your letter dated December 14, 2007 and our subsequent discussions since then regarding this report.

Included in this report are several findings along with our recommendations which are intended to further enhance and improve dental access for children. We will continue to focus our attention on the State's demonstrating effective oversight of its managed care contractors relative to children accessing dental services according to the EPSDT dental periodicity schedule.

As we stated in our earlier letter, we plan to conduct a follow-up review within a few months of implementation of these recommendations. Please continue to keep us posted on your progress with the implementation of the recommendations.

Once again, I want to express our appreciation for your staff's cooperation and their efforts in preparing for and participating in this review. If you have any questions or concerns, please contact either me at (215) 861-4275 or Rosemary Feild at (215) 861-4278.

Sincerely,

A handwritten signature in black ink that reads "Ted Gallagher". The signature is written in a cursive style.

Ted Gallagher
Associate Regional Administrator

Enclosure

cc: Jean Moody-Williams

**Final Report on Maryland's
Early and Periodic Screening,
Diagnostic and Treatment (EPSDT) Program
With a Focus on Dental Services for Children
February 5, 2008**

**CMS On-Site Review
October 18, 2007**



Executive Summary

The Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program for children enrolled in Medicaid is intended to assure the availability and accessibility of required health care resources and to help children to effectively use them. On October 18, 2007, a Centers for Medicare & Medicaid Services (CMS) EPSDT Review Team met with officials at the Department of Health and Mental Hygiene (DHMH), the agency responsible for administration of Maryland's Medicaid program, to discuss the policies and procedures being followed in fulfilling the requirements of the State's EPSDT program, with the focus on providing complete and comprehensive dental care to children. On November 28, 2007, CMS released this report in draft to DHMH and requested their response to our findings and recommendations. On December 14, 2007, DHMH sent CMS their response. CMS then reviewed the DHMH response and following subsequent discussions with DHMH, CMS incorporated most of their response into this report.

DHMH officials acknowledge that improvements are needed in its dental provider networks in order to meet the oral health needs of its enrolled children. They acknowledge that the advertised Medicaid dental provider network was shown earlier this year to be unreliable. DHMH officials are fully cognizant of the factors associated with the inadequacy of its dental provider network and with low utilization of dental services by the children enrolled in Medicaid, whether in a fee-for-service or managed care delivery system. Further, it is clear that the Medicaid beneficiary community does not understand the importance of oral health to the health and well-being of children through their lifespan.

In response to the recognized concerns related to dental services, the DHMH Secretary convened a Dental Action Committee to develop recommendations on increasing access to dental care. The committee developed a Dental Action Plan which the DHMH Secretary presented to the Maryland General Assembly in January 2008 for funding of measures to improve the participation of dentists in Medicaid and to increase families seeking dental care for their children enrolled in Medicaid. In the interim, DHMH initiated steps in May 2007 to hold the managed care organizations (MCOs) accountable for directing children to the dentist, including:

- MCOs were required to confirm to the State the accuracy of their dental directories, including whether the provider accepts new patients and any limitations, and MCOs must repeat this activity every six months.
- MCOs must directly assist all individuals requesting help with dental appointments with a confirmed appointment by the following day. MCOs report to DHMH weekly on actions and outcomes.
- MCOs must contact children aged five to 14 years without a dental visit in the past three years, and report on their progress in receiving dental services; health department staff conduct extensive investigations on failure-to-contact cases. This will continue until all children without a dental visit are contacted. MCOs report to DHMH weekly on actions and outcomes.

In addition to these required actions on the part of the MCOs, DHMH sent a letter to all dental providers, Federally Qualified Health Centers (FQHCs), local health departments, physicians providing well-child care, and MCOs, emphasizing the dental benefit package for

Executive Summary (continued)

children. DHMH is asking stakeholders to encourage parents of children on Medicaid to seek regular dental care for their children.

The EPSDT Review Team strongly urges DHMH to further strengthen its oversight of its contracted MCOs in the provision of dental services to children. The dental networks must be continuously evaluated and tested, beyond the assurances given by the MCOs, to ensure that they have adequate capacity to provide all enrolled children the dental services to which they are entitled under the Medicaid program. The MCOs must also be held accountable for informing and supporting families in understanding the importance of oral health care and in making and keeping dental appointments.

This report addresses the EPSDT key areas, with the exception of screening services. The narrative is limited primarily to information related to findings and recommendations. For easy access, the recommendations are listed below.

Recommendations

1. Issue to families a separate member handbook on dental services for children; written in appropriate cultural and linguistic style for easy understanding; and including information on the importance of preventive and routine dental care, age-appropriate dental services, how to access dental providers and transportation, and how to ask for help.
2. Establish an internal system to independently verify MCO dental provider directories, e.g., secret shopper or calls to participating dental providers.
3. Instruct the MCOs to track and report on children not receiving dental services and to escalate steps to reach such children, and enroll them into care. Such efforts should also include health department follow-up; contact with the PCP; Women, Infants, and Children Program; schools; and other community links.
4. Document the oral health needs of special needs children and the adequacy of dental specialists to meet their needs as a first step in developing an action plan to improve dental services utilization for special needs children.
5. Require MCOs to monitor and report on dental provider utilization. Analyze dental claims data, including utilization and dental-related emergency room visits, to identify network problems and to develop corrective action and/or intervention to ensure access to beneficiaries.
6. Initiate sanctions against any MCOs not meeting contractual obligations in the provision of dental services, in accordance with Federal managed care regulations as stated in 42 CFR 338.

**Maryland EPSDT Review Report
Focus on Dental Services
October 18, 2007 Site Visit**

CMS Review Team

Rosemary Feild, Region III Maryland Medicaid Representative
Cindy Ruff, EPSDT Coordinator
Diane Gerrits, Project Officer for Maryland 1115 HealthChoice Waiver
Conan Davis, D.M.D., Chief CMS Dental Officer

Department of Health and Mental Hygiene (DHMH) Participants

John Folkemer, Director, Deputy Secretary, Health Care Financing
Susan Tucker, Executive Director, Office of Health Services
Diane Herr, Director, HealthChoice & Acute Care Administration
Amy Gentile, Chief, Division of HealthChoice Management & Quality Assurance
Susan Harrison, Analyst, Office of Health Services
Martí Grant, Chief, Division of Healthy Kids Program (EPSDT)

CMS Participants in Entrance/Exit Conferences

Jean Moody-Williams, Director, Division of Quality, Evaluation & Health Outcomes, Center for Medicaid and State Operations
Ted Gallagher, Associate Regional Administrator, Division of Medicaid and Children's Health Operations, CMS Region III

I. Background

Maryland has struggled with poor access to dental services for a number of years. The State expected that the Medicaid managed care system, known as HealthChoice, would improve the access problems for its lowest income children. Further, since 1999 the State's dental program has operated under legislative oversight, and DHMH must report annually to the General Assembly on strategies to improve dental access and impact on utilization of dental services. These collective actions have helped to improve access, but still most children enrolled in Medicaid are not receiving dental services.

Following the death of a 12-year old in February 2007 from a brain infection caused by untreated dental problems, the U.S. House of Representative's Oversight and Government Reform's Subcommittee on Domestic Policy held hearings on *Oversight Adequacy of the Pediatric Dental Program for Medicaid Eligible Children*. The Subcommittee criticized the adequacy of Maryland's managed care dental networks for children, citing UnitedHealth Group's inaccurate contact information for many providers, and few providers accepting new patients, as revealed by congressional staff calling network dentists.

In May 2007, the Secretary, Department of Health and Mental Hygiene (DHMH), convened a Dental Action Committee, comprised of DHMH officials, the dental associations, University of Maryland Dental School, the advocate community, and other stakeholders. The Secretary charged the Committee with making recommendations on increasing access to dental care for underserved children in Maryland. This group met over the summer of 2007

Final CMS Report of October 18, 2007 Maryland EPSDT Review with Dental Focus

and in September 2007 submitted to the Secretary a Dental Action Plan. The Secretary presented his proposal to the General Assembly in January 2008 to fund implementation of the plan beginning July 2008.

The Maryland Dental Action Committee wrote that, "In sum, our oral health care support structure for low-income, special needs, and other underserved at-risk Marylanders lacks adequate dental provider capacity and oversight. Despite the requirements of EPSDT, we fail to assure that Medicaid-enrolled children access needed dental treatment services." The Dental Action Plan offers numerous recommendations to improve access to dental services for children, but primary focus rests with seven recommendations:

- Initiate a statewide single vendor dental Administrative Services Only (ASO) provider.
- Increase dental reimbursement rates to the 50th percentile of the American Dental Association's South Atlantic region charges, indexed to inflation, for all dental codes.
- Maintain and enhance the dental public health infrastructure through the Office of Oral Health by ensuring that each local jurisdiction has a local health department dental clinic and a community oral health safety net clinic.
- Establish a public health level dental hygienist to provide screenings, prophylaxis, fluoride varnish, sealants, and x-rays in public health settings.
- Develop a unified and culturally and linguistically appropriate oral health message for use throughout the State to educate parents and caregivers of young children about oral health and prevention of oral disease.
- Incorporate dental screenings with vision and hearing screenings for public school children or require dental exams prior to school entry.
- Provide training to dental and medical providers to provide oral health risk assessments, educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children.

II. Scope of Review

The EPSDT program consists of two, mutually supportive, operational components:

- Assuring the availability and accessibility of required health care resources, and;
- Helping Medicaid beneficiaries and their parents or guardians effectively use them.

The intent of this on-site review was to discuss and review with the appropriate State staff the policies and procedures being followed in fulfilling the requirements of the State's EPSDT program, with the focus on providing complete and comprehensive dental care to children. We also gathered information to demonstrate how the EPSDT requirements are being implemented, especially the dental services.

III. Introduction to Maryland Dental Services for Children

Maryland operates its Medicaid program primarily through a Section 1115 demonstration waiver, called HealthChoice, in which most children, approximately 400,000, are enrolled in seven mandatory managed care organizations (MCOs). Five of these MCOs - Amerigroup, Coventry, Helix Family Choice, Priority Partners, and Maryland Physicians Care - contract with a single dental benefit manager (DBM), Doral. Jai Medical Systems conducts its own dental benefits administration, and UnitedHealth Group contracts with a subsidiary DBM. These MCOs are contractually responsible for meeting EPSDT requirements. (Maryland recently responded to CMS on compliance with Federal managed care quality assessment and performance improvement requirements at 42 CFR 438.206 – 438.210 related to dental services.)

There are two groups of children that are carved out of managed care – approximately 2,800 children in the voluntary Rare and Expensive Case Management program (REM), having conditions such as Cerebral Palsy, and Spina Bifida, and about 200 children in the model Home and Community Based Services Waiver for Medically Fragile Children who are technology dependent. These groups receive dental services on a fee-for-service basis.

If Maryland goes to a single ASO vendor, all dental services will be carved out of managed care.

IV. Review Descriptions, Findings and Recommendations

Key Area A - Informing Families and Providers on EPSDT Services

States must provide for a combination of written and oral methods designed to effectively inform all EPSDT eligible individuals and their families about the program, the benefits of preventive health care, where services are and how to obtain them, and that needed transportation is available.

Informing Enrollees in Managed Care Delivery System

In Maryland, an eligible child receives a Medicaid card with contact information even before enrollment in an MCO. Services are available through fee-for-service before enrollment into the managed care delivery system. The MCO then sends each new enrollee a welcome letter and MCO member handbook (English and Spanish versions) listing all services covered, including dental services, how to obtain information on providers, and information on the individual's annual right to change its MCO. Enrollees receive an updated member handbook every year.

Finding #1: The EPSDT Review Team felt that the sample member handbook's reading level is too high and that dental information could be easily overlooked amidst a voluminous amount of medical information.

Recommendation #1: Issue to families a separate member handbook on dental services for children, written in appropriate cultural and linguistic style for easy understanding; including information on the importance of preventive and routine dental care, age-

Final CMS Report of October 18, 2007 Maryland EPSDT Review with Dental Focus

appropriate dental services, how to access dental providers and transportation, and how to ask for help.

DHMH Response: DHMH will make sure that all MCOs send culturally and linguistically appropriate information to families on how to access dental services including information on the importance of preventative and routine dental care, age-appropriate dental services, how to access dental providers and transportation, and how to ask for help regarding services. In fact, we are currently developing a template for the MCOs to use as an insert with their current handbooks that is dedicated to dental services. In addition, we are considering carving dental services out of the MCOs and into a single administrative services organization (ASO). If we do contract with an ASO, a separate member dental handbook will be part of the project.

CMS Response: If the dental program insert is implemented under current dental services arrangements, it is suggested that this method of highlighting and informing families about dental services be evaluated, and consideration be given to a separate member handbook if the insert is not found to be as effective as expected.

Under the HealthChoice Program, MCOs issue to enrollees a separate provider directory that includes a listing of dentists and identifies those accepting new patients. The House Subcommittee on Domestic Policy discovered and UnitedHealth Group later conceded that its provider listing was not reliable, in that many dentists were no longer under contract, had inaccurate contact information, or did not accept new patients. In response to this finding, DHMH instructed HealthChoice MCOs in May 2007 to contact and confirm for every currently contracted network dental provider the accuracy of information, agreement to accept new patients, and any limitations to open enrollment. MCOs must report to the State with an update on each dental provider every six months.

Finding #2: Given the finding that the dental provider directories were unreliable, DHMH's oversight should include an independent means to verify the dental provider directories.

Recommendation #2: Establish an internal system to independently verify MCO dental provider directories, e.g., secret shopper or calls to participating dental providers.

DHMH Response: Under current administrative procedures, each MCO is required to completely validate its dental directory every six months. When we receive the new directory information, DHMH will do spot checks for validity. However, provider participation is a dynamic process and directories are only completely accurate on the day they are printed. Therefore we have required each MCO to assist enrollees in making appointments during the initial call or by close of business on the following day. In addition, the Department has required the MCOs to submit a weekly report on all enrollee requests for dental care starting on June 4, 2007.

CMS Response: It is recommended that the spot checks be institutionalized.

Informing Providers

The majority of pediatricians in Maryland (about 80%) accept children enrolled in Medicaid. An EPSDT nurse team trains and certifies new primary care providers (PCPs), monitors each on a routine basis, and coordinates with the MCOs in these activities to improve quality of care. The physician encounter form incorporates all EPSDT requirements related to education, assessment, and treatment. The EPSDT team has over 20 years of experience working with practice-based reviews, with an emphasis on prevention.

The EPSDT provider manual advises PCPs to check a child's mouth and teeth at each visit. Then they score the provider on how well the standards for oral health are met, including an oral health exam, anticipatory guidance (education of parents on oral health), and referral to a dental provider. The problem is that the PCPs have difficulty in finding dentists for their patients.

In May 2007, DHMH sent a letter to all dental providers, Federally Qualified Health Centers, local health departments, physicians providing well-child care, and MCOs, reminding them of the dental benefit package for children. The letter stressed the vital role of physicians and nurse practitioners in educating parents on the importance of dental care and in referring children to dentists, as required under EPSDT. DHMH and the MCOs should ask all providers to report problems with dental referrals. Further, there could be a mechanism for the EPSDT nurse team to identify children not getting dental services and target them for outreach by the MCOs, ACCU or local health department.

In addition to the Maryland Medicaid Advisory Committee's collaboration with the dental community, there is renewed interest in reactivating the Oral Health Advisory Committee. This Committee could play a vital role in the State's outreach to the dental provider community. Dental provider input in an on-going way is crucial to their participation and ownership in the status of children's oral health in Maryland.

Key Area B - Periodicity Schedules

Section 5140 of the State Medicaid Manual provides the requirements for periodic screening and dental services and indicates that distinct periodicity schedules must be established for each of these screening services.

Managed Care Enrollees

The State requires participating dental providers to follow the American Academy of Pediatric Dentistry's periodicity schedule for oral health care, and monitors the MCOs to ensure that they inform providers and monitor utilization. The first dental visit must be no later than 12 months of age, then twice a year after two years of age. DHMH officials agreed to instruct the MCOs/Dental Benefit Managers (DBMs) to review dental records as part of the credentialing process of dental providers.

Finding #3: The State should hold the MCOs (or ASO if that be the case) accountable for all children receiving dental visits according to the prescribed periodicity schedule.

Recommendation #3: Instruct the MCOs to track and report on children not receiving dental services and to escalate steps to reach such children and enroll them into care.

Final CMS Report of October 18, 2007 Maryland EPSDT Review with Dental Focus

Such efforts should also include health department follow-up; contact with the PCP; Women, Infants, and Children Program; schools; and other community links.

DHMH Response: MCOs are responsible for providing an adequate provider network and for informing families about how to access dental services. As part of this requirement, MCOs develop and implement outreach strategies to encourage the use of dental services. This includes strategies such as giving parents \$10 bonuses or gift certificates if they take their children for appointments. We also expect MCOs to facilitate entry into care when enrollees call and request appointments. Ultimately, of course, parents must make sure their children receive necessary health services.

We do not expect MCOs to be local public health or school agencies. However, to help parents, our HealthChoice program includes funding for an outreach and care coordination unit in each local health department. This staff is responsible for providing education and outreach to hard-to-reach non-compliant patients. Providers and MCOs can request such assistance from local health departments. Unfortunately, you have informed us that this is no longer considered an appropriate Medicaid administrative activity, so federal matching funds will no longer be available for these local health department programs that have been providing this assistance since HealthChoice began ten years ago.

Regarding tracking utilization, the Department and MCOs have encounter data information on which children receive and do not receive dental services. The data are not real time, but can be used for initiatives to outreach to children who have not received dental services over some period of time. This is the information we are using to outreach to parents whose children have not received dental care in the last three years. Early results of this effort are not promising. MCOs have found that much of the contact information on the eligibility files is out-of-date. Please note that enrollees are asked to inform the Department of Social Services when personal data changes, but the most transient high-risk populations on the Medicaid program frequently do not comply with this requirement. These are the very people that are least likely to get primary and preventive services, including dental check-ups.

CMS Response: According to State officials, there are many out-of-network dental services provided by the MCOs. The State accepts no excuses for MCOs denying out-of-network services. The MCOs report on denials of care, but not on out-of-network care. Tracking information on requests for and provision of out-of-network dental services would serve as a source of information on potential problems with network capacity.

Special Needs Clients in FFS

State officials concede that the special needs population does not have adequate dental utilization, in spite of outreach efforts. It is difficult to get dentists to take care of special needs children, including the developmentally disabled, who may need extra time and attention, including anesthesia, in order to be able to receive dental treatment. Dentists need special training to serve this population. The University of Maryland has a dental clinic and there is a health department clinic on the Eastern Shore of Maryland, both of which have the capability to provide dental services to these difficult-to-treat patients.

Finding #4: Particular attention must be given to meeting the oral health needs of special needs children, particularly since their medical needs are so great.

Recommendation #4: Document the oral health needs of special needs children and the adequacy of dental specialists to meet their needs as a first step in developing an action plan to improve dental services utilization for special needs children.

DHMH Response: We already have the documentation on the use of dental services for special needs children. As we explained in the site visit, the State has case management vendors who are responsible for linking special needs children with dental providers. We will share the information with the vendors for the REM and the Model Waiver programs and ask them to redouble their efforts to make appointments for dental services for these children. Unfortunately, parents of special needs children have admitted to us that dental services are not a priority because the children have so many other needs that they put before preventative dental services.

CMS Response: We appreciate the State's plan to increase efforts in securing dental appointments for special needs children. We also recommend closely evaluating and documenting the ability of the dental community to meet the challenges posed by serving special needs children, and to work with the dental community in responding to these challenges.

Key Area C - Interperiodic Dental Services

In addition to the periodicity schedule, States must provide for dental services at other times when deemed medically necessary.

There are no findings for Interperiodic Dental Services.

Key Area D - Diagnosis and Treatment Services

Diagnostic services must fully evaluate the physical condition that was identified, while treatment services must ensure health care is provided to treat or ameliorate the physical condition. These services are limited by what is coverable under section 1905(a) of the Act, but may not be limited to services included in the Medicaid State plan.

There are no findings for Diagnosis and Treatment Services.

Key Area E - Support Services

The State is required to ensure that beneficiaries have adequate assistance in obtaining needed Medicaid services by offering and providing, if requested and necessary, assistance with scheduling appointments and non-emergency transportation.

There are no findings for Support Services.

Key Area F - Coordination of Care

EPSDT services are to be a continuum of care with the child's screening services delivered by someone familiar with his/her episodes of acute illness and an on-going relationship with the family as the regular source of the child's health care.

There are no findings for Coordination of Care.

Key Area G - Utilization of Providers and Coordination with Related Programs

EPSDT services are to be performed by or under the supervision of a licensed Medicaid physician, dentist, or other provider qualified under State law to furnish primary medical and health services.

Adequacy of the Dental Network

Maryland's dental network is grossly inadequate for the needs of its children enrolled in Medicaid. Since there is no standard for a beneficiary-to-provider ratio for oral health, DHMH uses the 1:2000 standard that applies to PCPs. However, this standard has not been analyzed for dental capacity as it has for primary care capacity. Moreover, at least one MCO's dental provider network has been proven to be unreliable as a source of participating dentists accepting new patients. The House Oversight Subcommittee found that only a handful of dentists in United's network provided the majority of dental services in Prince George's County.

Finding #5: The State is ultimately responsible for ensuring that the dental provider network is sound and capable of meeting the dental service needs of children enrolled in Medicaid. One aspect of oversight should include analysis of dental provider utilization, including which providers are claiming for dental services.

Final CMS Report of October 18, 2007 Maryland EPSDT Review with Dental Focus

Recommendation #5: Require MCOs to monitor and report on dental provider utilization. Analyze dental claims data, including utilization and dental-related emergency room visits, to identify network problems and to develop corrective action and/or intervention to ensure access to beneficiaries.

DHMH Response: The MCOs and the Department already monitor and report on dental provider utilization. We analyze dental encounter data, including utilization and dental-related emergency room visits, to identify network problems and to develop corrective action and/or intervention to ensure access to beneficiaries. In compliance with this recommendation, we will take more direct action in this area.

CMS Response: We appreciate the State's response.

Finding #6: It appears that one or more MCOs may not have fully met their contractual obligation to demonstrate the capacity to meet the enrolled children's dental needs, in accordance with the State's defined dental access standards.

Recommendation #6: Initiate sanctions against any MCO not meeting contractual obligations in the provision of dental services, in accordance with Federal managed care regulations as stated in 42 CFR 438.

DHMH Response: We will initiate sanctions against any MCO not meeting contractual obligations. Currently, MCOs are meeting contractual obligations.

Key Area H - Data Collection, Analysis and Reporting

There are no findings for Data Collection, Analysis and Reporting.

V. Conclusion

Even though there has been some improvement in the number of children receiving dental services in Maryland's Medicaid program, as reflected by EPSDT data over the past three years; this improvement is simply not sufficient, when at best only about 40 percent of children are receiving any dental service. DHMH officials are fully aware of the problems related to children accessing dental services, most critical of which is a severely inadequate dental provider network. In the past several months, the DHMH has taken appropriate steps to hold the MCOs accountable for ensuring that children enrolled in Medicaid receive dental care. These actions will continue and will be closely monitored by DHMH.

The DHMH Secretary's Dental Action Plan recommendations are a solid start in correcting problems on a broader scale in the longer term, but any budgetary action would not take place until 2008. The EPSDT Review Team reminds DHMH officials of their ultimate responsibility to see that Medicaid children receive dental services, and to adequately oversee their MCOs to ensure that they meet their contractual responsibilities in this regard. The recommendations in this report are intended to supplement and reinforce the steps taken by DHMH, to further strengthen the accountability of the MCOs, and to increase State oversight of the MCOs, particularly regarding the dental provider network.

Mr. KUCINICH. We have eight States which have a utilization rate below 30 percent, and that is 5 years after that first report in 2006, after this was first addressed. Five States still have utilization rate below 30 percent, which means that those young people eligible for those services, there is only 30 percent of all the eligible children are getting care, or less than that, in these States: Arkansas, Delaware, Florida, Michigan, Missouri, Nevada, New Jersey, and Wisconsin. We really need to find out these numbers and to submit those, and I would like you to help us and get these numbers and submit them to the subcommittee.

Mr. SMITH. Mr. Chairman, we would be happy to work with you to track down the numbers from the States. We will try to get you the data and will assist in collecting the information from the States.

Mr. KUCINICH. I want to just share something with Mr. Shays before I turn this over to him.

We are trying to work with Mr. Smith in a cooperative way so that he can produce this information. I met with him yesterday, and he has indicated his frustration in the way these information systems are set up, but CMS not being aware of it is really a barrier to being able to make sure that these services get delivered. I mean, that is just one of the issues. So I thank my friend. If you would like to join in, I would appreciate it.

Mr. SHAYS. I would like to ask a few questions. Again, Mr. Chairman, thank you.

When this story came out, I was stunned, frankly, because I had not heard of how debilitating and then life-threatening the lack of care of your own teeth could be in your mouth, and I want to ask was this a really isolated case? I mean, like, was this one out of a few or does this young man represent tens of children in each State? So tell me that. And I throw it open to any of you.

Dr. EDELSTEIN. Mr. Shays, it is an excellent question, and it is something that has not been thoroughly researched. What we do know—I am currently working with a dental resident who is looking just at greater metropolitan New York City hospital records. What we have learned so far is that the frequency of head and neck-associated brain abscesses is really quite a bit higher than any of us had anticipated. What we are trying to sort out now is how many of those are related specifically to dental origin.

It turns out that, talking to the neurologists and neurosurgeons, what was really different about Deamonte Driver is that he succumbed to a brain infection. So it is not the—

Mr. SHAYS. So the answer is that this is something that we are checking out. So you are not coming back to me and saying, hello, Mr. Shays, we have 100 of these in each State or something like that, cases like that. That is not the case right now.

Dr. EDELSTEIN. Well, actually, I think—

Mr. SHAYS. We just don't know.

Dr. EDELSTEIN. Well, we don't know. What we do know is that there are many, many brain infections, airway infections, and major facial infections.

Mr. SHAYS. And so what is causing that, is it a dental issue?

Dr. EDELSTEIN. That are from teeth, yes.

Mr. SHAYS. Great.

Dr. Crall.

Dr. CRALL. I was going to say that shortly after Deamonte's death, many of us are on a variety of listservs, and certainly in the dental public health world it lit up over individuals who, over the years, had accumulated files of similar types of death, and in the same week a youngster died on a school bus in Mississippi from a dentally related condition.

Mr. SHAYS. I mean, it is clearly something we should look at, and that I am not trying to minimize, but what it is saying is, as you are pointing out, we need statistics and documentation.

I have seen adults with teeth that are rotting, and I realize I pass judgment like, you have to be a real fool taken care of, but then I think, I would sooner die than you stick me in an MRI in a tube, where I am—I would not do it; you would have to knock me out to get me to do it. So some of the problem, just a phobia about sitting in a dental chair and that simply people just are deathly afraid to have that kind of experience. In other words, is the fear that I have of being claustrophobic, which would keep me from doing things that could help me, is that the same kind of fear that somebody has when they have to sit in a dental chair?

You are looking at me, Mr. Smith, like what the hell is he asking. I am not communicating with you. I know adults who are so afraid to go to the dentist they would sooner let their teeth rot. I have no sympathy for that. And yet I think, well, you know what, there are certain things I wouldn't do because of a phobia I might have.

Dr. CRALL. I think I would make two responses to that. One is that, yes, it is true that some adults actually really have a serious phobia about going to the dentist, but situations like that are much more common when they have had bad experiences early on, and that is generally from the not getting care in a timely way. So that the experience going to the dentist is not the routine experience that most of us happen to experience. That is why we really try to emphasize the importance of the ongoing care and the routine care, because even as unpleasant as some people may feel getting a filling or a restoration is, it really is a substantial issue.

The other is the financial side of things. I used to be at the University of Connecticut. We did a study for NIH that looked at the reasons for tooth loss in adults, and it was very clear that there are many, many salvageable teeth, as well as lots of unsalvageable teeth—

Mr. SHAYS. I do have a few more questions.

With your permission, if I could continue for two or three more minutes. Is that all right?

Is the threat of bad dental care more severe to a child versus an adult? In other words, can an adult have bad teeth and not have them affect him or her the same way as if he were a child? Is the outcome the same and is it as quick in terms of deterioration?

Dr. EDELSTEIN. It is not as quick in terms of deterioration. The adage about children is that they get sicker faster, they get better faster.

Dr. CRALL. But blindness, death, all of those things are consequences that can occur in adults as well as children.

Mr. SHAYS. The technology has improved. I happen to visit the dentist more than I would like, so I feel like I am an expert on new technologies. It is pretty impressive. Is that technology not available as much for a child under Medicaid, given that those who are poorer may not be able to go to doctors who have the best technology, or is that not an issue?

Dr. EDELSTEIN. I believe that the technology that is available to children, if they can find their way into a dental office, is equivalent. The problem is getting into the dental office.

Mr. SHAYS. We have community-based health care clinics in our district that are stunning and serve the whole community. Is that one way to really start to reach more young people?

Dr. EDELSTEIN. Without question, the safety net is an important place that needs to be bolstered. If you take a look, though, at the dental programs in, for example, FQHCs, there are many FQHCs that have no dental facilities and many dental facilities in FQHCs that have no dentists.

Mr. SHAYS. Finally, let me just make this point.

Thank you, Mr. Chairman.

Our staff has written some excellent questions that I didn't choose to go to because I was so curious about my own, but if they could extend a few questions that you might be willing to respond in writing, that would be helpful.

Again, Mr. Chairman, thank you. I am going to get on my way, but I thank you very much.

Mr. KUCINICH. The Chair would like to associate himself with your request.

So we would appreciate your cooperation in responding to Mr. Shays' questions. And the point that you made, even beyond the statistics, there is the human factor here about children's lives being put at risk, which is why these hearings become very important.

The person who has been one of our partners on this is Mr. Cummings from Maryland, who is very familiar with this case. I am going to ask Mr. Cummings to continue this hearing and to take the chair, and we will proceed shortly.

[Pause.]

Mr. CUMMINGS [presiding]. Thank you very much. I want to thank you all for being here this evening. Hopefully, we won't hold you too much longer.

But I must say that when we held our hearing last May, we invited three major stakeholders to testify before us: Mr. Dennis Smith, from the Centers for Medicaid and Medicare Studies; Ms. Susan Tucker, from the Maryland Department of Health and Mental Hygiene; and Dr. Alan Finkelstein, from the United Health Group. Only one of those individuals sits before us today, and that is Mr. Smith, and this is not without reason. In the intervening months since our May hearing in the year since Deamonte's death, the State of Maryland has stepped up to the plate in its efforts to improve children's access to dental health.

Governor O'Malley, who I was just with a few minutes ago—and that is the only reason I am late, because we had a delegation meeting—convened a Dental Action Committee which developed seven recommendations to better serve our children, including:

raising reimbursement rates for dental services; initiating a single State-wide vendor for dental services; spending \$2 million per year to enhance the dental health infrastructure; providing dental screenings for children; creating a new dental hygienist position; improving education for dental students; and crafting a public education campaign on oral health. The Governor included the first three items in his 2009 budget and he is currently working with the Dental Action Committee to implement the others, and I certainly applaud him for that.

Similarly, the United Health Group has stepped up to the plate to do its part. Following our hearing in May, the company invested \$170,000 for a program at the University of Maryland Dental School to improve children's access to dental care in Baltimore City, including more than \$30,000 to hire a pediatric dentistry case manager, more than \$60,000 to hire a pediatric dentistry fellow, \$30,000 to establish a mini pediatric dentistry clinic, and \$15,000 to provide continuing education to pediatric and family practice residents.

The company is now working to develop a similar partnership with Howard University that will reach across the Maryland border to Deamonte's hometown in Prince George's County.

I wish I could say that our Federal partners have been as cooperative as our State and private sector ones have been. Sadly and painfully, I cannot.

In our May hearing, Mr. Smith, you repeatedly implied that you had no enforcement tool for ensuring that children get access to dental care under the Medicaid program. So we sent you a seven page letter outlining the various steps you could take. To be sure, you have taken some of these steps, but I am significantly underwhelmed by your lack of urgency. Our children simply cannot wait. They can't wait.

I understand that since our last meeting CMS has completed an audit of the State of Maryland and is currently planning to audit 15 other States. Notably, the Maryland audit was completed in October, but CMS did not finalize it until February, after the subcommittee informed CMS of our intention to hold this hearing. In addition, target dates for the other 15 States range from February 11th to April 7th of this year, all after CMS received notice that this hearing would take place. I find it extremely troubling that CMS failed to initiate this investigation without pressure from this subcommittee.

Further, I understand that you, Mr. Smith, met with the chairman and staff yesterday to discuss CMS's work on this issue and did not know the answers to even the simplest questions about what the agency has done. I can't even begin to tell you what I am feeling with regard to the job that you are doing. Your own lack of knowledge illustrates the priority with which you treat this issue. I certainly hope that you are better prepared to answer questions today.

On that light, can you tell me more about the investigation and why it did not begin sooner? And then I have a whole series of questions.

Mr. SMITH. Thank you, Mr. Cummings. I think we began the review in October. That review included issuing a draft to the State

of Maryland, giving them the opportunity to respond, which we received in mid-December. And we wanted to have their response before we completed the review, which is why, the day after we sent the review to Maryland, we sent it up to the subcommittee as well.

Mr. CUMMINGS. Mr. Smith, as we understand it—and you correct me if I am wrong—CMS played a negligible role in Maryland’s reform. In fact, Maryland’s Department of Health and Mental Hygiene wrote a letter to Chairman Kucinich on this matter.

The letter makes it very clear that CMS had nothing to do with Maryland’s dental reforms. Mr. John Colmers, Maryland’s DHMH Secretary, explains that he initiated the Dental Action Committee in June 2007 and that CMS did not even begin its audit in Maryland until October 2007, and only finalized its findings early in February of this year. And I understand what you just said about December.

In fact, Mr. Smith, rather than help Maryland enact those reforms, you may have hindered their efforts. Let me explain.

According to your final report on Maryland’s EPSDT program, with the focus on dental services for children—which I would like to enter into the record by unanimous consent—Maryland’s DHMH states that it funds an outreach and care coordination unit in each local health department to provide outreach and education for the hard-to-reach non-compliant patients.

However, you informed Maryland that “This is no longer considered an appropriate Medicaid administrative activity, so Federal matching funds will no longer be available for these local health department programs that have been providing assistance since health choice began 10 years ago.” Are you familiar with that?

Mr. SMITH. I am familiar, sir.

Mr. CUMMINGS. Can you explain that to me so I can have a better understanding?

Mr. SMITH. I would be happy to. I think what the State was referring to was an entirely separate regulation on school-based administrative costs. For the State of Maryland to send in employees of the State to go in and to do outreach, to do enrollment, those are all reimbursable administrative expenses that the Federal Government would match. The issue of the school-based administrative claiming guide was due to issues that have dated back a number of years regarding abuses in the system in schools to where many different things were being billed to the Medicaid program, including school construction. Again, I certainly am not taking issue with the importance of school construction, but we don’t believe that is properly billed to the Medicaid program.

Mr. CUMMINGS. Well, what have you done to help Maryland?

Mr. SMITH. I’m sorry?

Mr. CUMMINGS. What have you done to help Maryland? To me, it seems like you—well, it appears that there are roadblocks, but what have you done to help them, Maryland?

Mr. SMITH. Well, I would like to think that our review did help Maryland in terms of—

Mr. CUMMINGS. How so?

Mr. SMITH. In terms of helping to identify areas that we believed were weaknesses in the program, that they agreed were weaknesses in the program, and I would like to think that we are work-

ing with Maryland as good partners. John Folkemer, who is the Director, used to work in our agency. We have a good relationship with Maryland. I would like to think that we continue to have a good relationship.

Mr. CUMMINGS. Now, the things that you came out with, did those come out after the recommendation of the Dental Action Committee?

Mr. SMITH. The Dental Action Committee made their report prior to our review.

Mr. CUMMINGS. And so, what, are you trying to take credit, in part, for what the Dental Action Committee had already done?

Mr. SMITH. No, sir, I am not trying to take credit for it.

Mr. CUMMINGS. And the reason why I say that is because the Dental Action Committee, I think, has done an outstanding job. And I guess what I am getting at is I want to make sure the Federal Government is doing its part to help States. I just left Governor O'Malley, and one of the things that he was saying to us in the delegation is that he wanted the Federal Government to step up to the plate not just in this, but in general, to help States accomplish the things that they need to accomplish.

And I am just wondering are there other things that you see that you might be able to do to help Maryland?

Mr. SMITH. Well, as I said, I hope that our review was helpful to Maryland.

Mr. CUMMINGS. Anything beyond the review, Mr. Smith?

Mr. SMITH. Specifically, Mr. Cummings, we match State dollars, so the State puts up its money first, and then we match that. I think what Maryland did in terms of the review and the Dental Action Committee, they have a good plan. We hope—

Mr. CUMMINGS. Is it one of the better plans that you have seen throughout the country? Are you familiar with other plans in other States?

Mr. SMITH. A number of States previously had plans. We are going out to review 15 States between now and April to look at what they are doing and, certainly, we share information between what we see are best practices. We have on our Web site now three States that we identify as best practices specifically in the dental area. States have a tendency to learn from each other, to pick up the information from each other. We have re-instituted the Oral Technical Assistance Group that we are working with the American Public Health Association. The Medicaid directors work through APHSA. They had some turnover on their staff, but we are discussing with them re-instituting the oral health TAG.

We have a number of different things going on with the dental officers themselves, the medical directors, that we hope will bear fruit from those discussions. The Association for Community-Affiliated Plans, which are kind of the not-for-profit managed care organizations, we have had discussions with them to help identify, again, good practices and how to spread that among the different States.

Mr. CUMMINGS. Do you believe that every child ought to have appropriate dental care?

Mr. SMITH. Yes, Mr. Cummings.

Mr. CUMMINGS. And do you believe your agency is doing everything in its power to work with the States to make that happen?

Mr. SMITH. I think, Mr. Cummings, that it is a shared responsibility and a shared role. I think that what we have—I think the focus on dental benefits in particular over the last several months are very important. We are happy to be a partner of that.

Mr. CUMMINGS. Do you—

Mr. SMITH. If I may, you mentioned the Dental Action Committee report in Maryland, which is a great example, but if the Maryland General Assembly doesn't fund it, they can't get Federal dollars if they don't put up their dollars.

Mr. CUMMINGS. Well, did you encourage States to increase rates when you redacted the section from the Guide? Remember we had that discussion about the Guide?

Mr. SMITH. We did have that discussion, Mr. Cummings. Again, I tried to explain. I thought it simply didn't belong in to what was a clinical guide.

Mr. CUMMINGS. So did you encourage the States to increase the rates? Did you encourage them?

Mr. SMITH. I'm sorry?

Mr. CUMMINGS. Did you encourage the States to increase the rates?

Mr. SMITH. As I said at the previous hearing, and what we have said subsequent to that, I think there is a widespread recognition that reimbursement rates in Medicaid are low and they are behind. Again, I guess I am struggling a little bit when I have clearly said I understand that rates are low and I have clearly said that there are a couple of key areas about gaining access, and reimbursement is certainly one of those key points.

But the Guide itself, it was my judgment that it just didn't belong in what I thought was a clinical—I mean, I can understand the concern if I were saying the opposite and I wanted to take something out that I didn't agree with, but I clearly have been saying that reimbursement in Medicaid is low and that is one of the major barriers to access.

Mr. CUMMINGS. Do you believe that some children ought to be left behind?

Mr. SMITH. No, sir.

Mr. CUMMINGS. Because you know that is what is happening, right?

Mr. SMITH. All Medicaid children should be receiving the care that they get. I believe that we have made progress. I think there is certainly more progress to be made, and the children on Medicaid should not have any less access than any other child. It is complicated, though, in terms of 38 percent—I believe the percentage of 38 percent of rural counties in America have no dentist. So I can't produce a dentist in a rural county for a Medicaid child if there is not a dentist for any other child as well. Those types of things that we find are, again, to overcome those takes a partnership, it takes, again, in many respects, in the Medicaid program it comes from the States putting up their share of the dollars.

If I may, the Federal Government funds direct grants. Congress has given money to CDC; Congress has given money to HRSA.

When you hear about conferences or special initiatives, it is because that is where the money has gone to.

In Medicaid, we don't have direct grant-making authority for those types of activities all on our own. We spend money because the States have spent money.

Now, there have been some exceptions to that. Congress specifically created, for example, the Real Systems Change Grants, helping people to get out of institutions and back into their own homes. But Congress specifically appropriated that, created that fund and funded the dollars for it. The Children's Health Act of 2000, where Congress again created grants. Unfortunately, funding was never appropriated for those specific grants. I believe it was \$10 million a year. But those dollars were not appropriated.

So, generally, when Congress has set out funding, they have put it in the public health service rather than CMS.

Mr. CUMMINGS. Did you have a comment, Dr. Edelstein? I saw you scribbling.

Dr. EDELSTEIN. A couple of thoughts. One is that the example of rural access is absolutely true, but an absolutely marginal issue. Children in areas where other children have ready—children in Medicaid in other areas where the children not in Medicaid have ready access to dental care also don't have access to dental care. In other words, the majority of places where children do readily access care, Medicaid children cannot. So it is not a question of whether there are enough dentists out there, period; it is a question of whether there are enough dentists whose offices are open to the children.

On the issue of CMS taking a leadership role in demonstrations, I don't know the internal financing and working of CMS—nor do I believe I should be expected to—but I do know that it was CMS that funded the demonstration in North Carolina that proved through the Into the Mouth of Babes program that you can enjoy better health outcomes at lower costs. And that was funded entirely by CMS, to the best of my knowledge.

Mr. CUMMINGS. Do you think we can do more of that, Mr. Smith?

Mr. SMITH. Mr. Cummings, if I may—

Mr. CUMMINGS. First of all, do you know if it was funded by you all?

Mr. SMITH. We funded it for 2 years. HRSA picked it up and they are funding it. So, again, we see it as a partnership with other partners that are involved.

Mr. CUMMINGS. And that money comes out of a certain pot? How does that work?

Mr. SMITH. I don't know what they are using.

Mr. CUMMINGS. Dr. Crall, did you have a comment?

Dr. CRALL. I believe CMS has funded demonstrations on a variety of issues, continues to fund demonstrations on a variety of issues, which I think would be very helpful in this case, as well as evaluation dollars, other types of things that could really identify key elements and programs that are working, elements and programs that are working better in some States than in others.

Mr. CUMMINGS. I look at this agreement that we were able to work out in Maryland with United. I mean, it is not a lot of money, it really isn't, \$170,000. I mean, that is not a lot of money, but you

are able to do a whole lot with it. I kind of think that we just need to have not only the will to do these things, but we have to make them happen.

When I see that little boy's face, I am just reminded of the way, Mr. Smith, that we get reports constantly from the University of Maryland that they are working with these young people, and they tell us that there are more and more kids that are just shy of where Deamonte was before he got real sick, in other words, that they are coming in to the dental chair and they have infections, some of them, and the infection goes to the eye, as I understand it, and it has not gotten to other organs.

But the fact is that these children are in trouble. And, fortunately, a lot of them are caught before that time, but this is America, this is the United States, and I think we can do better.

And I think that one of the things that has concerned me overall—and it is just not in this area, but generally—is that I think we are operating in a culture of mediocrity, where we kind of allow people to fall to the wayside as if it is OK. But it is not OK, because if it were your child, I am sure that you would do everything in your power to make sure that child had the kind of care that child needs. I just think that we could probably be a little bit more innovative and do a little bit more so that we can touch these children before they leave us.

Before I get to Ms. Watson, one of the things that I am always thinking about is how we, as adults, have a responsibility to our children to make sure that they are OK, and I just think we can do more. I just really do. And I think that if we cannot do more, then we don't need to be in the jobs that we are in. We really don't. We need to go and do something else, and let somebody else come in who can do those jobs so that we don't leave children behind with infections going to their eye sockets. I mean, this is not some Third World country, and you are the man, you know?

Mr. SMITH. Mr. Cummings, if I may, I provided in my opening statement—

Mr. CUMMINGS. I am sorry I missed it. I am sure it was spell-binding.

Mr. SMITH. Medicaid will spend \$2,900 per child for a full year. And, again, the general impression kids are healthy, they don't cost much because they are healthy, I think that is generally true, but Medicaid will be spending \$2,900. I mean, I agree with you passionately, why aren't we getting better value for the investment that we are making and the dollars that we are spending? And I think the health care spending in general—and Medicaid is going to be similar to what else is going on—but health care spending is driven by under-utilization and over-utilization, and to get them right is the optimum dollars. I mean, we do talk a great deal about the cost of health care in the United States, about how much we spend more than any other country.

Mr. CUMMINGS. Let me go to Ms. Watson. My time has been up. And then we will come back to revisit this.

Ms. Watson.

Ms. WATSON. Thank you so much. I must apologize for going out. While Representative Kucinich was here, I know that he was hop-

ing that I would raise some of the issues that he would like to raise.

If I am repeating the questions that have already been asked, would you stop me, please?

I am going to address Mr. Smith, because I know that you are aware of the Omnibus Budget Reconciliation Act of 1989, and it significantly revised the EPSDT benefits as enumerated in the Social Security action with regard to dental care, the OBRA exempted dental services from requirements of the general health screening services, and created a separate regulatory scheme for them.

Among other changes, the OBRA mandated that each State develop its own periodicity schedule for dental services and examinations, and I know you are aware of that. Regulations outlining the OBRA amendments were never promulgated. Instead, the then existing HCFA wrote Part 5 of the State Medical Manual, which is only guidance and does not have the force of regulation. So, today, Federal law is contradictory, because whereas the statute requires that each State must develop a periodicity schedule, existing regulations say that dental schedules will be federally set and dental referrals must be made by a physician at the age of 3. That is for a child.

So this is rather confusing, Mr. Smith, and does not make clear what the law is. So my question is, to you, how many States have developed a specific dental periodicity schedule in consultation with the dental professional organizations, are you aware?

Mr. SMITH. Ms. Watson, we do expect every State to have their periodicity tables. That is one of the things that we will be checking on our review to make certain that they have the periodicity tables.

Ms. WATSON. As I understand, there are only two States that have such schedules. Is that true?

Mr. SMITH. I don't think that—we would have to check. That doesn't sound—

Ms. WATSON. Well, if my information is true, that means that 48 States have not complied with Federal law, and this may be in part the results of lack of clarity on the CMS plans. And I would like you to look into it so you can get back to us. I think we are seeing the results of States not having these plans, and my colleague would agree, because—did Deamonte live in your district?

Mr. CUMMINGS. No, he didn't, but, Congresswoman Watson, Maryland is a small State, so I guess he would be about 40 minutes away from me. He was more like in Wynn's district, closer to Washington.

Ms. WATSON. So it is very important to us—and one of the reasons why we are having this hearing—to explain, because it is a contradiction and we need to see that all States have such plans.

Mr. SMITH. I agree, Ms. Watson. If I may expand a little bit. The law itself under EPSDT makes it clear that a Medicaid child does have the benefit of preventive care, restorative care, etc. So, in many respects, whether the State—the current periodicity table is—the child, if they need care, is entitled to that benefit regardless of whether the State ever did a periodicity table.

Ms. WATSON. Well, maybe we should clarify that.

Dr. Crall.

Dr. CRALL. Yes, Ms. Watson. In my opinion, the real value of periodicity schedules are that they not only deal with the broad rights of the child under a program, but they are definitive in terms of accommodating professional guidelines about when children should receive certain types of services and what services they should receive on an ongoing basis. Those are incredibly important for States translating that information into coverage decisions and also just sending the message about the need for early care and ongoing care for children, and periodicity schedules do that. And they do not exist in—

Ms. WATSON. You are from UCLA, aren't you?

Dr. CRALL. Yes, ma'am.

Ms. WATSON. That is my alma mater. I was in California in the State senate and I chaired the Health and Human Services Committee for 17 years. I have been away from there since 1998. Do the math. Ten years. And one of the things I did was to be sure that every patient walking into a dental office would be aware of amalgams. Do you know they did not do that? I had to hold hearings here. I have been away a long time. I came here in 2001. And we had to have hearings to force some leadership.

So what I would like to say, Mr. Smith, is that we need leadership. We need you to stay on these States, the 48. I will give that two States have promulgated the—and really understand what the mandate is. For your leadership to be effective, you need to see that they follow through. We can't have another death like we experienced with Deamonte. That is a shame on all of us. So I wish you would followup with that.

Will you be doing anything to come up with new regulations in accordance with OBRA?

Mr. SMITH. OBRA 1989?

Ms. WATSON. Yes.

Mr. SMITH. At this time, we don't have plans to do further regulations on OBRA 1989. Again, one of the things that we are doing in the review of the 15 States that we started this week and will be doing through April, I think that we have a number of different areas that we are looking at from support and coordination, beneficiary information, that sort of thing. So I think what we are—the strategy that we are really using is to be able to do those reviews and, as Maryland responded through the Dental Action Committee, where deficiencies were acknowledged and owned up to and the State came up with a plan to make those improvements, I believe we will see those same types of strategies take place.

Ms. WATSON. I see that Dr. Edelstein might want to add to this discussion.

Dr. EDELSTEIN. Ms. Watson, if I could. I would like to relate the tremendous importance of OBRA 1989, which, as you note, was never acted upon. Eighteen years now. I would like to relate that to prevention, because the real answer to improving children's health—not just whether or not they get a dental visit, but whether they are healthier than they are now—relies on prevention and disease management.

In those 18 years, the professional guidance on the appropriate age to start dental services has changed. With the recognition that tooth decay is an infectious disease that is established before age

2, periodicity schedules that call for starting at age 3 are, on the face of it, inappropriate. You can't start doing preventive services the year after a child acquires a disease.

So the importance of OBRA 1989 enactment—and now the regulations that need to follow from that—is that a clear message would be sent to the medical community, to the dental community that Medicaid is up to speed with what the science says about the importance of starting early. And having a periodicity schedule that calls for anything less than age 3 should be rejected by CMS based on the science.

Thank you.

Ms. WATSON. Mr. Sherman, I am just reminded of the hearings that you participated in with such leadership yesterday, when we were looking at the use of these enhancing drugs and steroids and so on, and what I saw as the purpose was to send a message out to young people, because we are involved with wellness. Dr. Smith, if we would keep people well, then the cost of Medicaid and Medicare would start to diminish. And, you see, America has to start looking at wellness, how to prevent illness, kind of like the Chinese system, where they pay the doctors to keep their patients well; and when they become ill, they must provide the health care free. We work the other way around and we pay the medical professionals big bucks after a person becomes acutely ill.

So we have to change our way of thinking. I am going to ask you, Mr. Smith, if you will look at at least checking to see what happened to those other 48 States that have not promulgated the regulations and get back to this committee in writing.

Mr. SMITH. We will do that, Ms. Watson.

Ms. WATSON. Please.

Mr. SMITH. Again, that is specifically a part of our protocol as we go out to the 15 States.

Ms. WATSON. Good. And I did hear you say the cost, and it is our responsibility, and we are dealing with a budget proposal for 2009, and one of the things I want to see, Mr. Chairman, is that we really look at Medicaid, Medicare and how we then start to put the dollars in, because we talk about homeland security. It is not about the land, it is about the people on the land, and we have to start with our young people and keep them healthy.

So thank you so much, and I want to thank the witnesses for being here. And thank you, Mr. Chairman, for giving me all this time.

Mr. CUMMINGS. Thank you very much, Ms. Watson. I just want to pick up where you left off.

To you, Mr. Smith, in looking over the fiscal year 2009 budget, I was surprised to see there are no increases for dental care, and I am trying to figure out why not additional funds, particularly when we know that there is such a tremendous need, Mr. Smith.

Mr. SMITH. Mr. Chairman, there will be an increase in funding as the services show up in the service categories. So it is all put together into medical assistance, it is not broken out separately. But Medicaid spending on dental care continues to increase every year.

Mr. CUMMINGS. OK. And how much did it increase over the last 2 years?

Mr. SMITH. I don't know offhand, Mr. Cummings, but we can provide that.

Mr. CUMMINGS. Can you get that to me?

Mr. SMITH. There is—the spending would be both on the fee-for-service side and the managed care side. On the fee-for-service side, that shows up because of their individual claims are submitted, but under a risk-based managed care it wouldn't show up because it would have been built into the rate that was paid to the managed care. So what we would provide would only be on the fee-for-service side, it would not include the managed care side.

Mr. CUMMINGS. Dr. Crall, in your testimony you talked about the importance of reimbursement rates to improving children's access to dental care. I want to turn our conversation to the State of Georgia. In your testimony, you have a table that shows that reimbursement in the State was raised to the seventy-fifth percentile and dentist participation went up. Is that correct?

Dr. CRALL. That is correct, Mr. Cummings.

Mr. CUMMINGS. So it went up about five, five and a half times, is that right?

Dr. CRALL. Yes.

Mr. CUMMINGS. But that is not the end of the story. Then we had the folks trying to pull out, is that right? Can you explain that, what happened, what you think happened?

Dr. CRALL. I will explain it to the extent that I am aware of the situation.

Mr. CUMMINGS. And then, Mr. Smith, you can tell us what you did about this.

Dr. CRALL. My understanding is that Georgia was using a global managed care arrangement and, therefore, payments were going to managed care organizations, who then would subcontract with other organizations to provide the dental services. And decisions were made to actually curtail and to reduce a number of significant providers of dental services within Georgia. I presume that was related to budgetary considerations, but that is typical of what often happens in a State where the significant changes are made in the rate structure.

The first thing that is going to happen is that the expenditures are going to go up. And if someone doesn't prioritize dental services and have a commitment to maintaining the effectiveness in increasing utilization that ensues because of those increases, what typically happens in States is they go through and they will cut dental expenditures along with many other programs. And dentists are aware of that situation and are very reluctant to join in to Medicaid because they get whipsawed around on this payment approach.

Now, we realize that many State budgets are under a fair amount of strain, but there are examples of other States—South Carolina and most recently in Texas and even in Connecticut—where they have recognized that the importance of giving their Medicaid rates into the market for dental services and have found ways to at least ensure that a solid core of limited—and not too limited, but a core of somewhere between the range typically goes from 45 to 80 procedures at least that cover basic dental services

that children need to take care of their disease are at a level that dentists will find to be acceptable.

So what happened in Georgia is typical of what has occasionally happened in other States, that the changes made, the increase in utilization ensues, expenditures go up, but then, all of a sudden, the rug is pulled out from under the program and that sends a very poor signal to other providers in the State about participating in Medicaid.

Mr. CUMMINGS. Do you want to comment on that, Dr. Edelstein?

Dr. EDELSTEIN. I would only add that Georgia is a particularly good example of how inappropriate contracting practices led to a squeeze on profits for for-profit Medicaid providers such that their only solution to protect their profits was to undo the very success that the program was intended to produce. The program is intended to produce care for children.

Mr. CUMMINGS. Right.

Dr. EDELSTEIN. In doing that, it costs too much for not the State, but the managed care company that was caught in the squeeze.

Mr. CUMMINGS. Right.

Dr. EDELSTEIN. They, therefore, cut services; the exact opposite of what the program is for.

Now, my question, and what I added in my testimony, was where was CMS at that time.

Mr. CUMMINGS. Yes. That is a good question.

Mr. SMITH. Mr. Cummings—

Mr. CUMMINGS. Well, I want you to know I was going to ask that question, but Dr. Edelstein beat me to the punch.

Mr. SMITH. In terms of Georgia specific, I would have to go back and find out the specifics on Georgia. In general, I know a couple of things have happened in Georgia. Georgia did switch to managed care, they switched into their S-CHIP program as well, and, as a result, Georgia expenditures have increased substantially.

Part of the reason why Georgia went to managed care was a loophole in the law that allowed managed care entities to pay a provider tax that, in essence, was paying the funding of the State appropriations. So the underlying finance of the Medicaid program created an incentive for Georgia to adopt almost a self-financing model, things like that which we have been trying to close off.

In managed care, though, in general,—and certainly my colleagues here can talk more sort inside the association than I can—dentists tend not to like managed care, regardless of it is in Medicaid or not. So Medicaid, yes, there is a piece of it there, but there is also something bigger than just Medicaid in terms of those relationships.

Mr. CUMMINGS. Yes, Dr. Crall.

Dr. CRALL. I certainly agree with the statement about dentists' hesitation about getting involved in managed care arrangements. Some of that stems from the fact that in the world of Medicaid dental services there have been managed care rates as low as \$2 to \$3 per child per month to provide care for Medicaid beneficiaries. No self-professionally respecting dentist would enter into any such arrangement. The only way that kind of an arrangement can work is to minimize children getting services, so that you inadequate col-

lect payments for each child, but collectively allow them to work on the few children that you treat.

So I think that while that is very true, I think that it also highlights the fact that when States learn about that and when they come to understand the way the systems work and the way the providers work, that has led many States to go to carve-outs from these managed care arrangements, to take their dental programs out of these global managed care arrangements and to deal with that particular issue.

And, in fact, it also reminds me of comments I made in my testimony about the series of policy academies that the National Governors Association initiated in the late 1990's. That gave us a great opportunity—and there was strong demand from the States; over 30 States applied for those. But it gave us the opportunity to really spend some time with some State officials to help them understand the fundamental issues, and I would say that every State that is on that list that I provided of States that made substantial changes and where we saw the increases in dentist participation and utilization, those States were States that participated in those processes. So anything that can be done to make it a priority within the State to get the State officials involved, strong leadership State officials involved, and to work with Federal partners to make that happen, I think we have a truncated track record of where that process can work.

Mr. SMITH. And, Mr. Cummings, if I may, we have had discussion with the Medicaid directors in terms of their managed care plans overall. We do believe that States need greater expertise in developing their managed care contracts, etc. Again, you often find you have a policy. The policy is just fine, but if you can't operationalize it correctly, then you have other problems. We did managed care in Virginia, and on the medical side, at the very least, managed care was very good for Medicaid beneficiaries in terms of the great increase in access, especially to specialists. That was lacking in the fee-for-service world.

So I don't want to just—managed care has a place. It needs to be done correctly and States need the expertise to be able to do good bids, to make certain there are actuarially sound rates. If those rates are actuarially sound, if they are built off solid data, if they are built off service utilization, then those should be good rates. But if you don't have that component, then you are going to end up with rates, and then your networks are going to fall apart.

Mr. CUMMINGS. All right, Ms. Watson.

Ms. WATSON. Thank you, Mr. Chairman.

We understand that CMS is preparing to re-institute the TAGs, and these are the technical advisory groups, the Oral Health Technical Advisory Groups. Is that so?

Mr. SMITH. Yes. We already have a number of TAGs, and we are in discussions with the Medicaid Directors Association. They need to be able to support it from their side. We have told the Medicaid directors we would like—

Ms. WATSON. So there is no guaranteed funding for them.

Mr. SMITH. We have contracts with AHPSA currently. We probably have to add a little bit more to that, but we have expressed an interest and willingness on our end to do so. And they have ex-

pressed a willingness also. They have had a transition and turn-over in their staff.

Ms. WATSON. I see. But you do see a way to fund these TAGs through some kind of arrangement?

Mr. SMITH. The oral health TAG?

Ms. WATSON. Yes.

Mr. SMITH. That is our intent, to re-institute the TAG.

Ms. WATSON. And I understand in the 1990's and in 2000 that the oral health TAG was convened to respond to questions from the States and from providers, but, to our knowledge, the findings have never been released. Can you comment why the findings that came out of the TAGs have not been released?

Mr. SMITH. I am not certain of what happened in the 1990's. The TAGs—

Ms. WATSON. In 1999, 2000.

Mr. SMITH. The TAGs themselves are a way to raise issues and they are a kind of ongoing discussions. I don't know that the TAGs themselves produced specific documents that would be public.

Ms. WATSON. Well, I would say that there should be an accounting of those discussions so that we could then fix the oral health system where there are failures, and that is another thing I would like you to look into for our knowledge, what yet needs to be done. Those TAGs were set up to have that two-way dialog, and I would hope that there would be some reporting as to what was found, what was learned, what we need to address. And if you could go back into the records, it would be very helpful to us.

Mr. SMITH. I would be happy. Again, we have 10 or 11 or 12 TAGs already.

Ms. WATSON. Yes, but what happened back when they were put together in the end of the 1990's?

Mr. SMITH. But in terms of the format, I don't know that they produced minutes, even. I would have to go back and find out.

Ms. WATSON. Dr. Edelstein, can you enlighten us on this?

Dr. EDELSTEIN. I would be happy to. I was privileged to serve as a technical advisor to the oral health TAG when it was formulated in 1999. The express purpose of the TAG at that time was to collect questions from the States regarding technical issues in the administration of Medicaid dental programs and, therefore, to share the responses of the experts back to the States. The first part happened; the second part never did.

Ms. WATSON. All right. So there is a collection, wouldn't you say?

Dr. EDELSTEIN. There is a document—

Ms. WATSON. A document.

Dr. EDELSTEIN [continuing]. That has each of the questions raised by the States and the answers responded to by the TAG.

Ms. WATSON. What was the title? What was the document title, do you remember? It would be TAG something.

Dr. EDELSTEIN. It is the report of the oral health TAG.

Ms. WATSON. OK.

Dr. EDELSTEIN. And Dr. Crall was also involved.

Ms. WATSON. Dr. Crall.

Dr. CRALL. Yes. The questions and the answers from that TAG can be found in Appendix D, I believe, of the material that the American Academy of Pediatric Dentistry submitted to CMS as

part of the dental guide. If it was not seen fit to publish that material in that form, I wholeheartedly concur with you that information does need to be made in some sort of public, ongoing basis—internet, CMS internet site, wherever.

Of course, as regulations change over time, the answers to those questions need to be adapted to reflect current policy, and I would really encourage CMS to make that an ongoing dynamic set of information that someone could go to and know the questions won't change that much. It is the answers that change as regulations and program changes. But the questions are the fundamental questions that people administering these programs in the State need to know to be able to operate their programs consistent with current policy.

Ms. WATSON. Through the Chair, I would ask Mr. Smith—and I am sure you have staff sitting behind you—if you could find that report. Good, you have already made—and I am going to ask my staff to make a note so I can raise this question in the full committee, Mr. Chairman, because I think that it would be very, very helpful to dentistry and to the practitioners and to us, as we plan ahead and as we budget, to know what the dialog, what the questions were, what the input was, what the assessment of all that was, from the TAG. And this is the reason why it was set up, so we will know what the dentists and I guess the patients, too—there will be some reference to patients, as well.

And if you could find that document and share it with us. And I think that needs to go out publicly, and we need to show that we are working to improve dental services to Americans, particularly to our children. So we want to know just what comes out of those advisory groups and how we can move forward with this.

So if it can be relayed to the subcommittee Chair, Mr. Chairman.

Mr. CUMMINGS. I have it. We will take care of that. I promise you.

Ms. WATSON. OK, good. Thank you so much.

Mr. CUMMINGS. I am just going to take two more minutes. First of all, I want to thank you all for your patience. I know you all have had a long day.

I have a request of you, Mr. Smith. We are concerned about Georgia and its recent cut in reimbursement rates. We want to find out if they are in violation of Federal law. Can you find that out for us?

Mr. SMITH. We will, Mr. Cummings.

Mr. CUMMINGS. What would be the procedure for accomplishing that?

Mr. SMITH. We will have to go back to see. If Georgia is not on our list, we will put them on our list and find out what happened.

Mr. CUMMINGS. So you have a list of States that you are trying to determine whether or not they are in violation of Federal law, is that what you are trying to tell me?

Mr. SMITH. We have a list of the 15 States to which we are starting to do our reviews.

Mr. CUMMINGS. Are you questioning whether or not they violated Federal law?

Mr. SMITH. I think that we would make that assessment based on the review.

Mr. CUMMINGS. OK. I just didn't know whether that was one of the reasons why you were looking at the 15 States. Do you follow what I am saying?

Mr. SMITH. I think there are seven different areas that we are looking at in the protocol.

Mr. CUMMINGS. OK. All right. The other thing I guess that I am concerned about, I just want to make sure that we are doing all that we can. You send all these guidelines out and you make all these requests of the various States, telling them what they can't do. I guess what I am hoping is that you will do more of telling them what they can do so that they can help kids. But it just seems to me like that is so much that is done to try to put the limitations on, but at the same time there doesn't seem to be a lot done to push them along to get them to do more. You follow me? And I know you may disagree with that. Talk to me.

Mr. SMITH. I think, again, as I said, we are spending \$2,900 per child, and if we are not communicating the value that we are getting for that in the Medicaid program, or if we are not doing an adequate job communicating what we think that, as we have laid out in our testimony and our strategy, we do believe that those will lead to increased quality and increased access. Clearly, the conclusions of the reports for the individual States we will certainly share with the subcommittee. We believe that we are pursuing strategies that involve multiple partners—not just the States, but the associations as well—and we believe that will be a successful strategy.

Mr. CUMMINGS. It is interesting that you cut guidance on how to oversee MCOs from the Guide. Are you familiar with that? Do you know that?

Mr. SMITH. Going back to the dental guide discussion we had, yes.

Mr. CUMMINGS. Yes. Because you had these philosophies about what shouldn't be in the Guide and what should be in the Guide, and I guess what I am trying to say is that some kind of way, Mr. Smith—and I say this with all the humility I can muster—I just think you could do a better job. I really do. And it pains me to even say that. But you are the person who has been put in a certain place at a certain time, and that position is to take care of a lot of human beings who may not have even been conceived six or 7 years ago.

Let me finish.

And I guess, I tell my staff that we are all given certain positions at certain points in our lives, and we are put there specifically to carry out a task and be effective and efficient. And if we can't do it, for whatever reason,—and I say this over and over again—do something else. Go play golf. Do something. But let somebody else come in there who will make a difference.

Because I don't want anymore Deamontes. And I say that. They live in my neighborhood. There are little Deamontes and little Chantes walking around in my neighborhood right now. When you go and eat dinner and celebrate Valentine's Day with your wife, they are going to be still in vulnerable positions tonight.

So I just think that we, as a country, can do better, and your organization has certain responsibilities. And Dr. Crall and Dr. Edelstein, I know, just listening to them, they have—I can hear

it—a level of frustration, and I guess it is very frustrating to me, because I just think that this is our watch. This is our adult watch.

So I am going to end there. Did you have anything else, Ms. Watson?

Ms. WATSON. No.

Mr. CUMMINGS. All right, thank you all very much. Unless you all wanted to say something else. I apologize. Did you have something else you wanted to say, Dr. Crall?

Dr. CRALL. Well, I would just close in saying that of the \$2,900 per child that is being spent, there are three actuarial studies that I am aware of that could send a signal to the States about the amount of resources that they ought to be putting into their dental programs. And I think that anything along those lines, as well as the periodicity schedules, that would send a clear message about exactly the types of services that children are supposed to receive and when they should receive that, those kind of signals need to be out there on an ongoing basis to emphasize this. And I couldn't agree with you more, we don't need anymore Deamontes.

Mr. CUMMINGS. If there are things, by the way, that you all feel that we need to be doing, you can get them to us in writing. We, hopefully—well, not hopefully. Next year there will be a new administration, and we may have to start there to try to get the new administration to begin to push on these things so that we can get some things done. But we welcome your advice because you all have dedicated your lives to touching these young people and you are where the rubber meets the road—you are there—and you do it everyday, so we want that information. So any recommendations that you would have for us, please pass them on, please.

Dr. Edelstein.

Dr. EDELSTEIN. I only wish to say that it is nearing the first anniversary of Deamonte Driver's death, and I wanted to recognize, on behalf of all the children who you and others are helping, how much you have not let down one moment in this year to highlight the importance of children's oral health, and we are anxious, all of us are anxious to work with you to continue to help to provide the technical information that will make it possible for you to do that. Thank you.

Mr. CUMMINGS. Again, as you have heard me say, Dr. Edelstein, when I was growing up, we expected to have cavities in our mouths. Low expectations. But a lot of our parents didn't know any better. But this is 2008 and we can do better as a Nation. We can do better.

Thank you, Ms. Watson. I know you had a long flight.

Thank you all. Happy Valentine's Day.

[Whereupon, at 5:55 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Elijah E. Cummings and additional information submitted for the hearing record follow:]

CONGRESSMAN ELIJAH E. CUMMINGS
OPENING STATEMENT

“ONE YEAR LATER: MEDICAID’S RESPONSE TO SYSTEMATIC
PROBLEMS REVEALED BY THE DEATH OF DEAMONTE DRIVER”

DOMESTIC POLICY SUBCOMMITTEE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
2154 RAYBURN HOUSE OFFICE BUILDING
TUESDAY, FEBRUARY 14, 2008
2:00 P.M.

Mr. Chairman,

Thank you for holding this vitally important hearing to examine Medicaid’s response to systematic problems revealed by the death of Deamonte Driver.

Based on what we have learned so far, I think our work today might better be described as an examination of Medicaid’s lack of response.

Mr. Chairman, as you recall, we sat in this hearing room nine months ago on May 2, 2007 in an effort to identify critical breakdowns in our Medicaid system’s ability to provide dental care to children.

We were here, at my request, because of a tragic incident that shook our nation.

Deamonte Driver, a 12-year-old boy from my home state of Maryland died one year ago this month¹ when an untreated tooth infection spread to his brain.

¹ February 25, 2007

Eighty dollars worth of dental care might have saved his life, but Deamonte was poor and he never made it to the dental chair.

That reality haunts me—and I am committed to ensuring that no other child suffers his fate.

We have our work cut out for us.

Deamonte's case was rare and extreme, but he was by no means alone in his suffering. The Centers for Disease Control and Prevention report that dental decay is the single most common childhood disease.

And poor children like Deamonte—children for whom the federal government guarantees dental coverage under the Medicaid program—all too often cannot find a dentist who will treat them.

Nearly 30 million children were enrolled in Medicaid in 2007, yet only one in three of them received dental care.

We must attack this problem from every possible angle, by engaging individuals who have the ability to fully address it.

When we held our hearing last May, we invited three major stakeholders to testify before us.

- Mr. Dennis Smith from the Centers for Medicaid and Medicare Studies;
- Ms. Susan Tucker from the Maryland Department of Health and Mental Hygiene; and
- Dr. Allen Finkelstein from the UnitedHealth Group.

Only one of those individuals sits before us today—Mr. Smith. This is not without reason.

In the intervening months since our May hearing—and the year since Deamonte’s death—the State of Maryland has stepped up to the plate in its efforts to improve children’s access to dental care.

Governor Martin O’Malley convened a Dental Action Committee which developed seven recommendations to better serve our children, including:

- Raising reimbursement rates for dental services;
- Initiating a single statewide vendor for dental services;
- Spending \$2 million per year to enhance the dental health infrastructure;
- Providing dental screenings for children;
- Creating a new dental hygienist position;
- Improving education for dental students; and
- Crafting a public education campaign on oral health.

The Governor included the first three items in his 2009 budget, and he is currently working with the Dental Action Committee to implement the others.

Similarly, the UnitedHealth Group has stepped up to the plate to do its part.

Following our hearing in May, the Company invested \$170,000 for a program at the University of Maryland Dental School to improve children’s access to dental care in Baltimore City, including:

- More than \$30,000 to hire a Pediatric Dentistry Case Manager;
- More than \$60,000 to hire a Pediatric Dentistry Fellow;

- \$30,000 to establish a Mini-Pediatric Dentistry Clinic; and
- \$15,000 to provide continuing education to Pediatric and Family Practice Residents.

The Company is now working to develop a similar partnership with Howard University that will reach across the Maryland border to Deamonte's hometown of Prince George's County.

I wish I could say that our Federal partners have been as cooperative as our State and private-sector ones, but I cannot.

In our May hearing, Mr. Smith repeatedly implied that he had no enforcement tool for ensuring that children get access to dental care under the Medicaid program—so we sent him a seven-page letter outlining the various steps he could take.

To be sure, Mr. Smith has taken some of these steps, but I am significantly underwhelmed by his lack of urgency.

I understand that, since our last meeting, CMS has completed an audit of the State of Maryland and is currently planning to audit fifteen other states.

Notably, the Maryland audit was completed in October but CMS did not finalize it until February, after the Subcommittee informed CMS of our intention to hold this hearing.

In addition, target dates for the other fifteen states range from February 11th through April 7th of this year—all after CMS received notice that this hearing would take place.

I find it troubling that CMS failed to initiate this investigation without pressure from this Subcommittee.

Further, I understand that Mr. Smith met with the Chairman and staff yesterday to discuss CMS's work on this issue and did not know answers to even the simplest questions about what the agency has done.

His own lack of knowledge illustrates the priority with which he treats this issue—and I certainly hope that he is better prepared to answer questions today.

A child died because of failures of the Medicaid program—and I cannot understand why everyone except the program's head recognizes the urgency with which we must address those failures.

I look forward to the testimonies of today's witnesses and yield back the remainder of my time.



**Statement of the
American Dental Education Association (ADEA)**

**"One Year Later: Medicaid's Response to Systemic Problems
Revealed by the Death of Deamonte Driver"**

**Before the
House Oversight and Government Reform
Subcommittee on Domestic Policy**

February 14, 2008

On behalf of the institutions that educate the nation's oral health care workforce and whose dental clinics provide significant dental care to many individuals enrolled in Medicaid, the American Dental Education Association (ADEA)¹ is pleased to offer its perspective regarding long-term improvements in Medicaid dental care.

The tragic death of 12-year old Deamonte Driver of Maryland dramatically emphasizes the unquestionable certainty that oral health is essential to the general health of Medicaid-eligible children. Deamonte's untimely death resulted from complications of an acute dental infection that spread to his brain. His hospitalization was estimated to cost \$250,000. Earlier dental treatment of his condition would have cost approximately \$80. His tragic story emphasizes the importance of identifying individuals with acute dental needs in the U.S. health care system and ensuring they obtain timely and necessary treatment.

Deamonte's death has focused national attention on the extensive disparities in oral health and medical care of millions of low-income, underserved individuals including children. The landmark 2001 publication entitled, "Oral Health in America: A Report of the Surgeon General," concluded that dental care is disproportionately available in the United States, depending on the racial, ethnic, and socioeconomic status of certain populations. Native Americans, Mexican Americans and non-Hispanic black populations are far more likely to have untreated dental caries than non-Hispanic whites.

Despite the value of Medicaid as the only public program that provides a guarantee of dental care to millions of poor and disadvantaged children, many factors impact their access to care. For example, states often have difficulty enrolling participating dentists in Medicaid due to reimbursement rates that are one-half to one-third of fees in private dental practice. Consequently, millions of children enrolled in Medicaid, although entitled to dental services, experience difficulties in receiving care.

The severity of the oral health access problem has intensified the call for policymakers to identify new solutions to meet the oral health needs of low-income children enrolled in Medicaid. Following is a description of children's dental benefits under Medicaid and the American Dental Education Association's recommendations to address some of problems that affect access to dental care for millions of children enrolled in Medicaid.

Children's Dental Coverage under Medicaid

All 25 million children in Medicaid 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. A 2000 survey of state Medicaid program administrators found that 96 percent of respondents reported an access problem for lower-income children in need of dental care. Poor children have twice the incidence of tooth decay as their non-poor counterparts. The problem is worse for children of ethnic and racial minority groups. Despite this fact, Medicaid spending for early and periodic screening is 0.4 percent of total Medicaid spending.

¹ The American Dental Education Association (ADEA) represents all 57 U.S. dental schools, 714 dental residency training programs, 285 dental hygiene programs, 271 dental assisting programs, and 21 dental laboratory technology programs, as well as the faculty, dental residents and dental and allied dental students at these institutions as well as 10 Canadian dental schools. It is at academic dental institutions that future practitioners and researchers gain their knowledge, the majority of dental research is conducted, and significant dental care is provided. Our member institutions serve as dental homes to thousands of patients, many of whom are underserved low-income patients covered by Medicaid and the State Children's Health Insurance Program.

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.

ADEA Recommendations

ADEA's academic dental institutions are often major dental safety-net providers in states through clinics in dental schools, dental residency training programs and dental hygiene programs. Many of ADEA member institutions have developed innovative ways to deliver oral health care to underserved populations. Through their access to state-of-the-art dental research our institutions also discover state-of-the-science evidence on oral diseases and conditions that lead to advancements in technologies and improved efficiencies in care. Our members' strong record as dental safety-net providers combined with the breadth of their oral health expertise, uniquely qualifies ADEA to offer the following recommendations to improve children's access to Medicaid dental care.

A. Eligibility

1. Preserve eligibility to a basic package of dental services under the EPSDT program for children eligible for Medicaid up to at least 200 percent of poverty. These children experience higher rates of tooth decay and are less likely to receive treatment. Any state plan to substitute the eligibility standards of the State Children's Health Insurance Program (SCHIP) or other programs that would weaken EPSDT would potentially eliminate critical dental services for millions of children. Alternatives to EPSDT would not reduce states' health care costs. Rather, they would significantly drive up costs by replacing the cost-effective preventive care provided by EPSDT with more costly emergency treatment.

B. Benefit Design

2. Prohibit states from imposing cost-sharing or annual limits on EPSDT oral health services to children. Beneficiaries with incomes below \$16,090 for a family of three saw their out-of-pocket medical expenses grow an average of 9.4 percent between 1997 and 2002. For these families their medical expenses grew twice as fast as their incomes (4.6 percent). For poor disabled beneficiaries the problem was worse, consuming 5.6 percent of their incomes. Furthermore, an analysis of 13 studies conducted in seven states show that cost-sharing reduces utilization. Medicaid should encourage beneficiaries to seek preventive and routine dental services that can save overall health care dollars and thereby eliminate the need for more expensive care in emergency rooms. Children who receive preventive dental services early in life have costs that are approximately 50 percent lower than those of children whose dental care is neglected over time.

3. Require state Medicaid agencies to update and develop EPSDT periodicity schedules for dental services to children in Medicaid in consultation with recognized dental organizations involved in providing dental services to children. Few state Medicaid agencies have published or made separate schedules available for dental services, even though several model schedules exist for EPSDT well-child dental visits (e.g., those included in the clinical guidelines prepared by the American Academy of Pediatric Dentistry and the National Center for Education in Maternal and Child Health).

4. Ensure adequate reimbursements for dental services. Medicaid beneficiaries should have the same level of access to dental care that is available for other health care services in

Medicaid. The program is the major source of oral health care for vulnerable and low-income populations. Unfortunately, enrollment in Medicaid does not ensure receipt of oral health care services. In 2002, total combined state and Federal spending on Medicaid dental services was \$2.7 billion or 1.1 percent of total Medicaid spending. In comparison, Medicaid spent \$8.9 billion for physician services or 3.6 percent of all Medicaid spending in 2002. Visits to dentists take longer than standard doctors' visits. Likewise, they require sophisticated technology, costly equipment and materials. Medicaid and other public health programs rarely take these differences into account when establishing reimbursement rates.

5. Adjust payments to dental providers who provide care to a disproportionate number of Medicaid patients, particularly those with complex medical and other special needs. Few states recognize the differences in the economies of dental practice and the impact that payment decisions have on provider incentives to provide significant amounts of dental care to Medicaid beneficiaries. Reimbursement for oral health and dental care should reflect these differences as well as the additional burden of disease and complexity of treatment for Medicaid beneficiaries, especially those with cognitive and physical disabilities that have special health care needs.

6. Develop models of care that allow primary care providers to gather data, assess, triage and refer patients to appropriate dental professionals for diagnosis and treatment. States should be encouraged to adopt models of care that develop stronger linkages between pediatricians, family physicians, geriatricians and other primary care providers as team members with dentists in assessing oral health status. Dental schools and oral health professionals would serve as team leaders providing the necessary education and training that would enable all primary health care professionals to assess the oral health status of their patients and make appropriate referrals to dentists and allied dental professionals. Such programs would enhance the oral health knowledge base of all health professionals and allow patients to access oral health treatment at an earlier stage in the delivery system. This would permit more cost-effective treatment of Medicaid beneficiaries before their dental disease manifests in a medical emergency requiring more expensive and costly treatment.

7. Develop innovative programs that increase access to oral health care, including collaborative partnerships between state Medicaid programs and academic dental institutions. In some states, the Medicaid program has been an innovative laboratory for dental programs and policies that increase access to dental care for low-income and vulnerable populations. These opportunities would be enhanced by providing additional funding through demonstration projects and other programs to foster innovative programs in states that expand access to services and improve dental care for Medicaid beneficiaries. Dental schools offer several advantages that fill gaps in state Medicaid oral health programs including: 1) access to research on oral disease and prevention; 2) model programs in educating the public regarding good oral health; and 3) experience in providing oral health services to Medicaid populations including those with special needs. (See attachment entitled "Academic Dental Institutions as Safety-net Providers" for highlights of some dental school activities in Medicaid.)

C. Quality of Care and Outcomes

8. Utilize Practice-Based Research Networks (PBRNs) such as those underway at the National Institute of Dental and Craniofacial Research (NIDCR) to identify and develop the evidence base for practice guidelines in oral health. In March 2005, NIDCR awarded three seven-year grants, totaling \$75 million, to establish practice-based research networks that investigate with greater scientific rigor the everyday issues surrounding the delivery of oral health care. The purpose of the PBRNs is to develop the research data to guide treatment decisions in the dentist's office. Each regional network will conduct approximately 15 to 20

short-term clinical studies comparing the benefits of different dental procedures, dental materials, and prevention strategies under a range of patient and clinical conditions. The networks also will perform anonymous chart reviews, as allowed by the Health Insurance Portability and Accountability Act (HIPAA), to generate data on disease, treatment trends, and the prevalence of less common oral conditions.

9. Conduct Dental Health Services Research. More analysis of oral health data for Medicaid is needed from the Agency for Healthcare Research and Quality (AHRQ) and from other Federal and state sources. From such data, measures of oral health status including measures specific to gender, ethnic and racial mix of the Medicaid population including children would emerge. Analysis should be prepared in consultation with dental researchers and might include information on the utilization, cost, cost-effectiveness, outcomes of treatment, measurement of disease and other health outcomes.

Conclusion

ADEA is grateful for the opportunity to share its recommendations for enhancing state and federal investments that will improve children's dental health in Medicaid. These investments are necessary to reduce preventable and costly emergency dental care and will help to ensure that no child in America will suffer the tragic fate of Deamonte Driver.

The American Dental Education Association stands ready to work with the Committee in identifying programs, policies and best practices that expand and enhance access to dental care in Medicaid through cost-effective and affordable means.

