

NECESSARY REFORM TO PEDIATRIC DENTAL CARE UNDER MEDICAID

HEARING

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

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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NECESSARY REFORM TO PEDIATRIC DENTAL CARE UNDER MEDICAID

TUESDAY, SEPTEMBER 23, 2008

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

The subcommittee met, pursuant to notice, at 10 a.m. in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Higgins, and Issa.

Also present: Representative Higgins.

Staff present: Jaron R. Bourke, staff director; Noura Erakat, counsel; Jean Gosa, clerk; Charisma Williams, staff assistant; Leneal Scott, information systems manager; Jill Schmalz, minority counsel; Molly Boyd, minority professional staff member; and Larry Brady, minority senior investigator and policy advisor.

Mr. KUCINICH. We have just been informed that the ranking member is en route and he urges us to start, so we will.

The subcommittee will come to order.

This is the Domestic Policy Subcommittee of the Oversight and Government Reform Committee. Today is Tuesday, September 23, 2008. The hearing today is entitled, "Necessary Reform to Pediatric Dental Care under Medicaid."

Today's hearing is going to examine the progress of reform in Medicaid's pediatric dental entitlement.

Without objection, the Chair and the ranking minority member will have 5 minutes to make opening statements, followed by opening statements not to exceed 3 minutes by any other Member who seeks recognition.

Without objection, Members and witnesses may have five legislative days to submit an opening statement or extraneous materials for the record.

Nearly a year and a half ago a 12-year-old boy named Deamonte Driver died of a brain infection caused by untreated tooth decay. Deamonte lived in Prince George's County, MD, and was a Medicaid beneficiary, and as such was entitled to dental care paid by the American taxpayers. But he hadn't seen a dentist for more than 4 years.

Since then my subcommittee began an investigation into the adequacy of pediatric dental care under Medicaid. In May 2007 my subcommittee held a hearing to determine the circumstances that led to Deamonte's preventable death. Nine months later we exam-

ined what corrective actions the Center for Medicaid and State Operations, CMS, had taken since Deamonte's death to reform the dental program for Medicaid-eligible children.

Today we seek to move beyond identifying problems with our pediatric dental program under Medicaid and start identifying the reforms necessary to fix a broken system. Moreover, we will have the opportunity to recognize Federal and State officials who have taken the lead in fixing this system by implementing some of those reforms.

After our May hearing, I instructed our 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 Healthcare's dental network and records of claims submitted for services rendered to United beneficiary children in 2006.

What my staff found was appalling. 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 4 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 Health Care's dental provider network was not nearly as robust as they claimed. We discovered that only seven dentists provided 55 percent of all dental services rendered in 2000 in the county where Deamonte resided.

Shortly after the release of our investigatory findings in October 2007 I instructed my subcommittee staff to expand its investigation into three managed care organizations in addition to United in three other States and counties. The survey, the results of which are made available to the Center on Medicaid and State Operations by letter last week, assessed United and Health Care Choice in Apache County, AZ; United and Amerigroup in Essex County, NJ; United and Keystone Mercy in Philadelphia County, PA; and Amerigroup in Prince George's County, MD.

I ask unanimous consent to enter my letter into the record.

The finding of this expanded investigation reveals that inadequate dental provider networks and poor utilization rates are not limited to any single MCO or to any single jurisdiction. The problems are system-wide.

Our survey revealed that many, many thousands of children enrolled in Medicaid are not receiving dental care for up to 6 consecutive years. We have a chart up that is supposed to represent that. I don't know if anybody is going to be able to read it. I certainly can't from here. But this slide indicates how many children did not see a dentist in 4 or more consecutive years.

The percentage of children enrolled in Medicaid without dental services for 4 consecutive years between 2003 and 2006 ranged between 25 and 31 percent across all States and MCOs. But percentages are one thing and numbers are another. This means that in Philadelphia County, for example, 34,947 children enrolled in Keystone Mercy did not see a dentist between 2003 and 2006. These are children who are entitled to this care.

Are any of those children suffering from untreated tooth decay? If so, will it be caught before it leads to another tragic story?

Our survey also revealed that dental provider networks are as woefully inadequate in these other jurisdictions and MCOs are as they were in Prince George's County in 2006.

In all jurisdictions among all MCOs examined, only between two and nine dentists performed half of all services rendered to children enrolled in Medicaid in fiscal year 2006. This is in Prince George's County.

United's provider network in Essex County, NJ, boasts of 203 dentists. At first glance, it appears that parents in Essex County can easily access a dentist to treat their child. But look a little closer and you will find that only 9 dentists of the 203 enrolled in United's provider network provided 50 percent of all services to children enrolled in the MCO.

Why are large numbers of dentists enrolled in a managed care organization's network but not providing care? What will it take to change their status from inactive to active providers of dental care for Medicaid-eligible children?

We began to explore answers to this question earlier this year. In February this subcommittee held a hearing to evaluate CMS's reforms in pediatric dental care under Medicaid since the death of Deamonte. The hearing revealed the inadequacy of the agency's reforms, prompting this subcommittee to press CMS to do more to achieve greater access to and utilization of pediatric dental care. My subcommittee made six policy recommendations to CMS in this vein.

I ask for unanimous consent to enter my letter into the record.

Since that time, CMS has come under new leadership. Today we will hear from CMS and learn that the agency has taken great strides in responding to these recommendations. CMS's accomplishments since our last hearing mark a significant and positive shift in its approach to providing dental care for our country's poorest children.

We will also hear from representatives of several State Medicaid agencies whose programs provide instructive lessons for other States struggling to improve their pediatric dental program under Medicaid. We will hear about the positive impact of increasing reimbursement rates in Maryland, about the positive impact of a disease management model in North Carolina, and about the positive impact of creating a single vendor administrator for dental care in Virginia.

The history of pediatric dentistry under Medicaid is deeply disturbing. The system of Government and private managed care companies that was entrusted by the American people to take care of children like Deamonte Driver has been in a shambles. According to the Government Accountability Office's most recent report on oral health, not much has changed over the past two and a half decades. GAO's report is the first of its kind since 2000, when the Surgeon General released a report on oral health in the United States and found that low-income children suffered twice as much from tooth decay than more affluent children.

But our hearing today is going to show that over the past year and a half, through congressional oversight, the tireless work of ad-

vocates, and the dedication of State and Federal officials, lessons have been learned since Deamonte's death. Initiatives have been undertaken, and a Federal agency, long accustomed to a laissez-faire attitude toward Medicaid has finally awakened.

I look forward to hearing the testimony from our witnesses and believe it will demonstrate to the American people that reform has come to Medicaid and society can be guardedly optimistic.

Thank you.

[The prepared statement of Hon. Dennis J. Kucinich and the information referred to follow:]

**Opening Statement
Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee
“Necessary Reform of Dental Care in Medicaid”
September 23, 2008
2154 Rayburn HOB
10:00 A.M.**

Nearly a year and a half 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 a Medicaid beneficiary, and as such was entitled to dental care paid for by American taxpayers. But he hadn’t seen a dentist in more than four years.

Since then my Subcommittee began an investigation into the adequacy of pediatric dental care under Medicaid. In May 2007, my Subcommittee held a hearing to examine the circumstances that led to Deamonte’s preventable death. Nine months later, we examined what corrective actions the Center for Medicaid and State Operations (“CMS”) had taken since Deamonte’s death to reform the pediatric dental program for Medicaid eligible children. Today we seek to move beyond identifying problems with our pediatric dental program under Medicaid and start identifying the reforms necessary to fix a broken system. Moreover, we will have the opportunity to recognize federal

and state officials who have taken the lead in fixing this system by implementing some of those reforms.

After our May 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 UnitedHealthCare's dental network and records of claims submitted for services rendered to United beneficiary children in 2006. What my staff found was appalling: 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 only seven dentists provided 55% of all dental services rendered in 2006 in the county where Deamonte resided.

Shortly after the release of our investigatory findings in October 2007, I instructed my Subcommittee staff to expand its investigation to three

managed care organizations (MCOs), in addition to United, in three other states and counties. The survey, the results of which I made available to the Center on Medicaid and State Operations by letter last week, assessed United and Healthchoice in Apache County, Arizona; United and Amerigroup in Essex County, New Jersey; United and Keystone Mercy in Philadelphia County, Pennsylvania; and Amerigroup in Prince George's County, Maryland. I ask unanimous consent to enter my letter into the record.

The findings of this expanded investigation reveal that inadequate dental provider networks and poor utilization rates are not limited to any single MCO or to any single jurisdiction. The problems are system wide. Our survey revealed that many, many thousands of children enrolled in Medicaid are not receiving dental care for up to six consecutive years. **[POINT TO SLIDE ONE]** This slide indicates how many children did not see a dentist in four or more consecutive years. The percentage of children enrolled in Medicaid without dental services for four consecutive years between 2003 and 2006 ranged between 25 and 31 percent across all states and MCO's. But percentages are one thing and numbers are another—this means that in Philadelphia County, for example, 34, 947 children enrolled in Key Stone Mercy did not see a dentist between 2003 and 2006. Are any of

those children suffering from untreated tooth decay? If so, will it be caught before it leads to another tragic story?

Our survey also revealed that dental provider networks are as woefully inadequate in these other jurisdictions and MCOs as they were in Prince George's County in 2006. **[POINT AT SLIDE TWO]** In all jurisdictions and among all MCOs examined, only between two and nine dentists performed half of all services rendered to children enrolled in Medicaid in FY 2006. United's dental provider network in Essex County, New Jersey boasts of 203 dentists. At first glance it appears that parents in Essex County can easily access a dentist to treat their child. But look a little closer and you'll find that only 9 dentists of the 203 enrolled in United's network provided 50% of all services to children enrolled in the MCO.

Why are large numbers of dentists enrolled in the Managed care organization's network but not providing care? What will it take to change their status from inactive to active providers of dental care for Medicaid eligible children?

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Deamonte. The hearing revealed the inadequacy of the Agency's reforms, prompting this Subcommittee to press CMS to do more to achieve greater access to, and utilization of, pediatric dental care. My Subcommittee made six policy recommendations to CMS in this vein **[POINT TO SLIDE 3]**. I ask for unanimous consent to enter my letter into the record. **Since that time, CMS has come under new leadership.** Today we will hear from CMS and learn that the Agency has taken great strides in responding to these recommendations. CMS's accomplishments since our last hearing mark a significant and positive shift in its approach to providing dental care for our country's poorest children.

We will also hear from representatives of several state Medicaid agencies whose programs provide instructive lessons for other states struggling to improve their pediatric dental program under Medicaid. We will hear about the positive impact of increasing reimbursement rates in Maryland; about the positive impact of a disease management model in North Carolina; and about the positive impact of creating a single vendor administrator for dental care in Virginia.

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Deamonte Driver has been in shambles. According to the Government Accountability Office's most recent report on oral health, not much has changed over the past two and a half decades. GAO's report is the first of its kind since 2000 when the Surgeon General released a report on oral health in the U.S. which found that low-income children suffer twice as much as from tooth decay than do more affluent children.

But our hearing today is going to show that over the past year and one-half, through congressional oversight, the tireless work of advocates, and the dedication of state and federal officials, lessons have been learned since Deamonte's death; initiatives have been undertaken, and a federal agency, long accustomed to a laissez-faire attitude toward Medicaid, has finally awakened. I look forward to hearing the testimony from our witnesses and believe that it will demonstrate to the American people that reform has come to Medicaid, and society can be guardedly optimistic.

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April 1, 2008

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Mr. Dennis G. Smith, Director
Center for Medicaid & State Operations
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Smith:

On February 14th you testified before the Domestic Policy Subcommittee hearing regarding the dental reforms in pediatric dental care in Medicaid since the inexcusable death of 12-year-old Medicaid-eligible child, Deamonte Driver. Driver died from a brain infection resulting from untreated tooth decay. In the course of the hearing you committed the Center for Medicaid and State Operations ("CMS") to follow-up on a number of issues. We list those issues below. Additionally, we would like you to address to several questions regarding reform of pediatric dental reform in Medicaid. We request your response in writing.

1. In addition to Maryland, there were 14 states that had less than a 30% utilization rate in 2001. They reported their utilization rates in response to the January 18, 2001 State Medicaid Letter. Additionally, according to the CMS-416 in FY 2006, fourteen states and the District of Columbia had a utilization rate below 30%. Eight of those states demonstrated chronic underutilization in 2001: Arkansas, Delaware, Florida, Michigan, Missouri, Nevada, New Jersey, and Wisconsin. Please report the total number of Medicaid eligible children that have not received dental services in each of these states in at least 3 consecutive years? 4 consecutive years?
 - a. Arkansas
 - b. Delaware
 - c. Florida
 - d. Michigan
 - e. Missouri
 - f. Nevada
 - g. New Jersey
 - h. Wisconsin

Mr. Dennis G. Smith
 April 1, 2008
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- i. Arizona
- j. California
- k. District of Columbia
- l. Georgia
- m. Kansas
- n. Louisiana
- o. Montana
- p. New York
- q. North Dakota
- r. Oklahoma
- s. Pennsylvania
- t. South Carolina
- u. Virginia

2. The *Omnibus Budget Reconciliation Act (OBRA) of 1989* significantly revised the EPSDT benefits as enumerated in the Social Security Act Section 1905(r)(3). With regard to dental care, the OBRA exempted dental services from requirements of 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.

Regulations outlining the OBRA amendments were never promulgated. So today, federal law is contradictory because whereas the statute requires that each State must develop a periodicity schedule, existing regulations say that dental periodicity schedules will be federally set and dental referrals must be made by a physician at the age of three.

During the hearing you agreed that every State should have a periodicity table and that you will examine whether or not every State has met that federal requirement. Please submit your findings to the Subcommittee.

3. The hearing revealed that the findings of the Oral Health Technical Advisory Group (TAG), convened between 1999 and 2000, were never released. The hearing also revealed that those findings constituted “Appendix D” of the material that the American Academy of Pediatric Dentistry submitted to CMS as a part of the Dental Guide in 2001 but which was redacted by CMS when it published the Guide in 2004. You agreed to locate those findings and, if still appropriate, to make them public. If you find that the findings are outdated, we suggest that you pose the same issues addressed in the ‘99/’00 TAG to the newly constituted Oral Health TAG. Please submit the findings from ‘99/’00 to the Subcommittee. Please also share your plans for handling the TAG’s finding from ‘99/’00.

Mr. Dennis G. Smith
 April 1, 2008
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4. In 2006, the Medicaid managed care organizations that offer dental care in Georgia, limited their available services and cut their reimbursement rates in order to protect their earnings. Their new policies may have threatened access to dental care for Medicaid eligible children in Georgia in violation of federal law. During the hearing, you agreed to assess whether Georgia's Medicaid policies violated federal law. You committed to doing so by adding it to your list of fifteen states under review for EPSDT compliance. Please share your findings with the Subcommittee.
5. We understand that CMS has resurrected the January 18, 2001 State Medicaid Letter and, as required by that letter, is in the process of conducting site visits to those states in which less than 30% of children had "any dental service" in the 2006 as measured by the CMS-416. We want to acknowledge this significant progress on your part.
 - a. What specific actions have you taken or plan to take in Maryland to implement the findings in your EPSDT review?
 - b. What is the strategy for fixing the problems uncovered?
 - c. Will you be paying extra attention to the eight states where less than 30% of all children had "any dental services" in each year from 2001 until 2006? If so, how?
6. In your testimony, you indicated that the estimated cost per child for a full year on Medicaid for all services in FY 2009 is approximately \$2,900. What percentage of that total is allocated for dental services? What percentage of that cost [per child on Medicaid per year for all services] was allocated for dental services in FY 2008? FY 2007? And FY 2006? What is the basis for determining the dental services allocation?
7. We praise you for creating a web site to highlight promising practices in dental care. We encourage you to identify more promising dental practices to highlight on your site. Additionally, we would like to know about CMS funding available for dental demonstrations.

In the late 1990's, CMS committed some of its scarce elective demonstration funds to dental varnish programs. One of those programs was North Carolina's "Into the Mouths of Babes," (IMB), Program. North Carolina's State Medicaid Director, Mark Casey, wrote the Subcommittee a letter in which he explains how successful the program has been and that it couldn't have been done without CMS's support. He writes, "...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 than infants and toddlers who have not received IMB services...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

Mr. Dennis G. Smith
April 1, 2008
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program... The five-year demonstration was initially funded by the Centers for Medicare and Medicaid Services..." North Carolina's success with the IMB program is a very innovative way of addressing dental care; it constitutes a good practice worth highlighting; and it started as a result of CMS funding.

- a. Have you promoted the IMB program on your web site of promising practices?
 - b. Will you commit CMS to providing funding to launch dental demonstration programs, such as IMB, in other states, and, if so, what is the level of funding allocated for that purpose?
8. At our hearing last May, the GAO reported that states reported only one-third of Medicaid children received any dental services in fiscal year 2005. GAO also said the reports and data were not complete or reliable. You affirmed the inadequate nature of the CMS-416 in your October 2007 as well.

This is perplexing, since your web site describes in *detail* how data for the CMS-416 should be collected. The purpose of the CMS-416 is to assess the efficacy of each State's EPSDT program, and the instructions are provided in order to generate reliable data. If you think that the data is "not reliable and comparable" as you have explained in your correspondence to the subcommittee, then it would seem to indicate a CMS failure to enforce federal law requiring reporting the information collected on Form CMS-416.

- a. What do you plan on doing to make the Form CMS-416 more reliable? If you do not have such plans, how can CMS address the problem of the low use of dental services by Medicaid children without a reliable data source?
- b. Additionally, you mention in your October 2007 letter that you sent out reminders to 22 states that had failed to submit their CMS-416 forms on time. Why are states habitually failing to provide this statutorily mandated report on time? This is a federal requirement and it is presently the only tool for comprehensive oversight that you have.

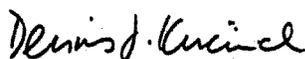
Please provide us with your response to these questions as well as the aforementioned documents no later than 5:00 p.m., Monday April 11, 2008.

Mr. Dennis G. Smith
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April 1, 2008

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides additional information on how to respond to the Subcommittee's request.

If you have any question regarding this request, please contact Noura Erakat, Counsel, (202) 226-5867.

Sincerely,


Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee


Elijah E. Cummings
Member of Congress

cc: Darrell Issa
Ranking Minority Member

HENRY A. WAXMAN, CALIFORNIA
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House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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September 19, 2008

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Mr. Herb Kuhn
Acting Director
Center for Medicaid & State Operations
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Kuhn:

Since the death of twelve-year old Deamonte Driver of Prince George's County, Maryland, who died of a brain infection caused by untreated tooth decay, the Domestic Policy Subcommittee has been investigating the adequacy of pediatric dental services under Medicaid. Our findings reveal that the dismal character of the Medicaid dental program in Maryland as it existed in early 2007 is not unique.¹ Instead, our findings demonstrate that inadequate access to and unsatisfactory utilization rates of pediatric dental care under Medicaid is prevalent in three other states and counties we surveyed, and among three other managed care organizations.

In the aftermath of its first hearing in May 2007, the Subcommittee launched a review of UnitedHealth Care's ("United")² documents and found that 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 Deamonte was in at the time of his tragic death. The review also revealed that United's dental provider network was not nearly as robust as United had claimed:

¹ In February 2007, twelve-year old Deamonte Driver, died of a brain infection caused by untreated tooth decay. A Subcommittee investigation into the matter revealed chronic underutilization among a significant number of children enrolled in UnitedHealth Care throughout Maryland as well as an inadequate dental provider network. Since the death of Deamonte as well the Subcommittee investigation, Maryland has taken significant steps to reform its pediatric dental care under Medicaid.

² UnitedHealthCare was the managed care organization responsible for Deamonte at the time of his death.

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Only seven dentists conducted 55% of all dental services rendered in 2006 in the county where Deamonte resided.³

Shortly after the release of our investigatory findings in October 2007, the Subcommittee expanded its investigation to four other states and counties and three additional managed care organizations (“MCO’s”) in addition to United. The Subcommittee sought to evaluate whether United’s woefully inadequate provider network in Prince George’s County and its extremely low utilization rate throughout Maryland were unique. The Subcommittee expanded its review of United in Apache County, Arizona; Essex County, New Jersey; Philadelphia County, Pennsylvania; and Providence County, Rhode Island.⁴ In addition to evaluating United’s performance in these jurisdictions, the Subcommittee also evaluated the performance of three other MCO’s with presence in those counties and states, these included: HealthChoice in Arizona, Keystone Mercy in Pennsylvania, and Amerigroup in New Jersey and Maryland.⁵

The Subcommittee reviewed the dental claims in FY 2006 for each of these MCOs to evaluate:

- (1) Whether services rendered in each county were provided by a broad spectrum of dentists, or whether they were provided by only a handful of dentists as was the case with United in Prince George’s County;
- (2) Whether there existed a significant number of children in each state who did not receive dental care for four consecutive years, between 2003 and 2006, as was the case with children enrolled in United in Maryland; and
- (3) Whether the dental provider network provided by each of the MCOs was accurate and reliable, or whether it was replete with erroneous listings including dentists that did not take any new Medicaid patients as was the case with United in Prince George’s County.

Our findings are as follows:

- (1) The percentage of children enrolled in Medicaid without dental services for four consecutive years between 2003 and 2006 ranged between 25 and 31 percent across all states and MCO’s;

³ Letter to United and Department of Health and Mental Hygiene from Domestic Policy Subcommittee, Committee on Oversight and Government Reform (October 2, 2007)(online <http://domesticpolicy.oversight.house.gov/documents/20071003151743.pdf>).

⁴ United’s presence in Rhode Island only amounted to one quarter of FY 2006 and therefore did not provide useful claims data to be included in the review.

⁵ Document Request submitted to United from Subcommittee (January 8, 2008); Document Request submitted to HealthChoice from Subcommittee (April 28, 2008); Document Request submitted to Amerigroup from Subcommittee (April 28, 2008); Document request submitted to Keystone Mercy from Subcommittee (April 28, 2008).

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- (2) In all jurisdictions and among all MCOs examined, between two and nine dentists performed 50 percent of all services rendered to children enrolled in Medicaid in FY 2006; and
- (3) The dental provider networks surveyed are marginally better than United's network in Prince George's County but still far from adequate. Our survey revealed problems in the accuracy of the provider listings as well as severe problems in access to dentists for children enrolled in Medicaid. Significantly, many of the dentists accurately listed are not willing to serve children enrolled in Medicaid. For example, in Prince George's County, Maryland, United's dental provider network was 70 percent accurate, meaning that 51 of its 73 listed dentists existed, had the correct contact information listed, and accepted Medicaid patients. However, the claims data demonstrates that of the 51 dentists accurately listed, 19 dentists provided zero services to eligible children in Prince George's County and that 22 of them provided services to only one child merely a single time. In effect, of the 51 accurate listings only ten of them are likely to see a child enrolled in Medicaid. Our review demonstrates that accuracy of the listings ranged from 42% (Philadelphia County, Keystone Mercy) to 80% (Apache County, UnitedHealth Care).

The following charts show our findings for each MCO in each state and county. Also, you will find a memo from the Congressional Research Service to the Subcommittee summarizing their analysis of the claims data done on behalf of the Subcommittee.

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**Chronic Underutilization: Lack of Dental Care in Four
Consecutive Years: 2003 - 2006**

Managed Care Organization		Pennsylvania - Philadelphia	Arizona - Apache	New Jersey - Essex	Maryland - Prince George's
Americhoice	Percent of Enrollees with No Service	28%	0.1%	28%	Note 2
	Number of Enrollees with No Service	10,225	69	22,231	10,780
AmeriGroup	Percent of Enrollees with No Service	N/A	N/A	25%	24%
	Number of Enrollees with No Service	N/A	N/A	5,715	14,076
HealthChoice	Percent of Enrollees with No Service	N/A	28%	N/A	N/A
	Number of Enrollees with No Service	N/A	8,948	N/A	N/A
Keystone Mercy	Percent of Enrollees with No Service	31%	N/A	N/A	N/A
	Number of Enrollees with No Service	34,947	N/A	N/A	N/A

Note: Enrollment numbers reflect enrollees who were enrolled over the four year period 2003- 2006 and received no services. **Note 2:** The Subcommittee's review of United's dental provider network in Prince George's County, Maryland took place in the Fall of 2007. At that time the Majority Staff did not request the total number of children enrolled in United between 2001 and 2006—having that number would have enabled the Subcommittee to determine the percentage of children with no services for four consecutive years. Instead the Subcommittee's figures only reflect the total number of children enrolled in United in each year between 2001 and 2006.

N/A - managed care organization does not enroll beneficiaries in county.

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Concentration of Dental Services Rendered: Number of Dentists in each county who provided 50% of dental services rendered for all Medicaid enrolled children in 2006

Managed Care Organization		Pennsylvania - Philadelphia	Arizona - Apache	New Jersey - Essex	Maryland - Prince George's
AmeriChoice	Number of providers that represent ~50% of care	8	2	9	7
	Total number of providers, percentage, and claims	(177 providers) 51.3% 18,753/38,160 claims	(76 providers) 50% of services 1104/2254 claims	(203 providers) 51.9% of services 7816/16404 claims	(73 providers) 50% of services
AmeriGroup	Number of providers that represent ~50% of care			9	8
	Total number of providers, percentage, and claims			(59 providers) 49.7% of services 2,638/5293 claims	(71 providers) 51.9% of services 12,433/23,966 claims
HealthChoice	Number of providers that represent ~50% of care		2		
	Total number of providers, percentage, and claims		(21 providers) 53% of services 166/312 claims		
Keystone Mercy	Number of providers that represent ~50% of care	4			
	Total number of providers, percentage, and claims	(160 providers) 53.7% 49, 635/92,493 claims			

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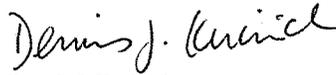
These troubling figures demonstrate that the oral health crisis that manifested in Maryland in early 2007 is imminent in at least four other states, regardless of which MCO is responsible for administering pediatric dental care under Medicaid. The Subcommittee fears that this could be true throughout the country as well.

The Subcommittee requests that CMS address these findings and identify how it proposes to substantially improve pediatric dental care under Medicaid. Please be prepared to do so during the Subcommittee's hearing on Tuesday September 23rd. Please submit something in writing as well.

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

If you have any questions regarding this request, Noura Erakat, Counsel, at (202) 226-5867.

Sincerely,



Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

Enclosure

cc: Darrell Issa
Ranking Minority Member



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Deputy Administrator
Baltimore, MD 21244-1850

SEP 22 2008

The Honorable Dennis Kucinich
Chairman, Domestic Policy Subcommittee
Committee on Oversight and Government Reform
House of Representatives
Washington, DC 20515

Dear Mr. Kucinich:

Thank you for your letter of September 19, 2008 sharing the findings of your staff and the Congressional Research Service (CRS) on the under-utilization of dental health services for children in Medicaid who are enrolled in certain Managed Care Organizations (MCOs).

The Centers for Medicare & Medicaid Services (CMS) is grateful to you and your staff for developing and providing this information. As you and I discussed during our meeting in May, I share your conviction that we must improve dental health care. I also share your desire that CMS and the Congress – and most importantly, the States who manage these programs – need to continue our joint efforts to improve the delivery of dental care for children in the Medicaid program. This important report is further evidence of that partnership, and we plan to take full measure of your findings.

In this regard, I believe the efforts of your staff and CRS provide a very important addition to our review of seventeen State dental programs. That report, which we expect will be completed shortly, looks at the various issues resulting in low dental coverage and utilization rates. One of the factors we identified is risk based contracting. Ultimately, this report will serve as the basis for our comprehensive effort to evaluate State performance, develop new policy options, and establish new accountability and performance metrics to be used by the States in the management of their dental programs.

To make sure the new information you are providing us is included in our evaluation, we need your assistance to help us obtain the additional data and analysis you used in developing your study. This will be critical to us as we evaluate and identify both strengths and weaknesses in managed care contracting. While we have had less than one working day to review your report, we have identified several important issues. In this regard, we believe, at a minimum, the following information will be instrumental to us in evaluating your report:

Page 2 – The Honorable Dennis Kucinich

1. You noted that a relatively small number of providers accounted for a large share of the paid dental claims. It is unclear as to whether the providers you referenced are individual providers performing a larger than expected number of services or if the provider is a group practice with multiple providers providing services through the one group.
2. It is not clear if the Subcommittee finds it an objectionable practice for providers to specialize in Medicaid services or services for children and adults with special needs (as the one plan cited as *Special Smiles Limited*) and thus, provide more services than other providers in the local area.
3. You referenced a provider network survey that revealed inaccuracy in provider listings. While you have provided summary findings, the specific inaccuracies were not identified for the health plans reviewed. It would be helpful if we could receive more information on your findings to accurately respond.

I look forward to continuing our partnership with you and the Subcommittee so that together we can ensure better oral health care for the children covered under the Medicaid program. Our Office of Legislation will be in contact with your staff regarding these questions and additional information that could assist us in our evaluation.

Thank you again for your important leadership in this area.

Sincerely,



Herb B. Kuhn
Deputy Administrator
Acting Director, Center for Medicaid
and State Operations

cc:
Darrell Issa
Ranking Minority Member



Memorandum

September 18, 2008

TO: House Committee on Oversight and Government Reform
 Subcommittee on Domestic Policy
 Attention: Noura Erakat

FROM: Elicia Herz and Rich Rimkunas
 Specialists in Social Legislation
 Domestic Social Policy Division

SUBJECT: Analysis of Medicaid Dental Claims for Children in Three States

To assist you in preparation for your Subcommittee hearing on September 23, 2008, at your request, we have analyzed dental claims data from selected Medicaid managed care plans in three states (Arizona, New Jersey, and Pennsylvania).¹ To supplement this claims analysis, we also provide analyses of FY2006 CMS-416 data, which documents receipt of dental services among Medicaid children eligible to receive early and periodic screening, diagnostic and treatment (EPSDT) services, a mandatory benefit for individuals under 21 in Medicaid.

Background

Lack of regular dental care can result in pain, infection and delayed diagnosis of oral diseases. During the 2001 - 2004 period, one-fourth to one-third of children ages 2 to 19 in families with income below 200% of the federal poverty level (FPL) experienced untreated dental caries, a sign that needed dental care was not received. In 2005, about one-third of all children living below 200% FPL did not have a recent dental visit.²

In 2006, 50.9% of individuals under the age of 21 in the U.S. had private dental coverage, another 30.4% had public dental coverage (primarily Medicaid and SCHIP) and 18.7% had no dental coverage. The percentage of individuals under age 21 that had a dental visit in 2006 varies by type of coverage – 58.0% with private dental coverage had a dental

¹ The committee also asked CRS to analyze activities in Rhode Island. The Rhode Island data reflected a single quarter (3 months) of data. This was not a long enough period of time to determine beneficiary access patterns or provider service activity. As a result, the Rhode Island information is not included in this memorandum.

² National Center for Health Statistics, *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*, Hyattsville, MD: 2007. Hereafter referenced as *Health, United States, 2007*.

visit that year, compared to 35.1% of those with public dental coverage and 26.3% of the subgroup with no dental coverage.³

With respect to the first dental visit, the American Academy of Pediatric Dentistry (AAPD) recommends that every child be seen by a dentist following the eruption of the first tooth, but not later than 12 months of age. All other children should have additional periodic dental exams every 6 months (i.e., twice a year). Under Medicaid, states must adopt a dental periodicity schedule which can be state-specific based on consultation with dental groups, or may be based on nationally recognized dental periodicity schedules, such as the AAPD's guidelines.⁴

One goal of the *Healthy People 2010* initiative is that at least 57% of low-income children receive a preventive dental visit each year.⁵ Most Medicaid children under age 21 are entitled to EPSDT services.⁶ The Medicaid statute (Section 1905(r)) defines required EPSDT screening services to include dental services which, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. In addition, care that is necessary to correct or ameliorate identified problems must also be provided, including optional services that states do not otherwise cover in their Medicaid programs. Beneficiary cost-sharing for services such as dental care is prohibited for children under age 18, and is optional for those between ages 18 - 21.⁷

The research literature has identified several factors that affect the use of dental services among children. From a beneficiary perspective, barriers include, for example, ability to pay for care, navigating government assistance programs, finding a dentist who will accept Medicaid, locating a dentist close to home (especially in inner-city and rural areas), getting to a dentist office, cultural or language barriers, and lack of knowledge about the need for periodic oral health care.⁸

³ See Manski, R.J. and Brown, E. *Dental Coverage of Children and Young Adults Under Age 21, United States, 1996 and 2006*. Statistical Brief (forthcoming). Agency for Health Care Research and Quality, Rockville, MD.

⁴ See Centers for Medicare and Medicaid Services (CMS), *Guide to Children's Dental Care in Medicaid*, October 2004, and the American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment of Children*, 2003.

⁵ U.S. Department of Health and Human Services. *Healthy People 2010*. Second Edition. Washington, DC: U.S. Government Printing Office, November 2000.

⁶ Children classified as "medically needy" (in most states, a small subset of all Medicaid children), may be provided EPSDT at state option. Although an official count is not available, we believe that all states currently provide EPSDT to this group. In addition, as an alternative to traditional Medicaid benefits, the Deficit Reduction Act (DRA) of 2005 allows states to offer benchmark plans similar to coverage in the employer-based insurance market to many groups of Medicaid beneficiaries. This DRA option provides access to EPSDT as a "wrap-around" to these benchmark plans for Medicaid beneficiaries under age 19, not under age 21, as in traditional Medicaid.

⁷ Under the DRA, cost-sharing is prohibited only for children in mandatory eligibility categories (e.g., the poorest children) and certain foster care/adoption assistance children. Exempted groups may nonetheless be subject to cost-sharing for non-emergency use of an emergency room and prescribed drugs at state option.

⁸ *Health, United States, 2007*.

Because most of the dental care provided in the U.S. is delivered by private dentists, their participation in Medicaid is critical to access to these services. Dentists typically cite three main reasons for their low participation rates in Medicaid: (1) low reimbursement rates, (2) burdensome administrative requirements, (3) and patient behavior (e.g., infrequent care-seeking behavior and high no-show rates for dental appointments).⁹ Medicaid law and regulations require that payment rates be sufficient to enlist enough providers so that services are available at least to the same extent that such services are available to the general population in the geographic area.

Managed Care Plans in Three Study States

In the past, benefits through managed care plans focused mostly on primary and acute medical care services. Delivery of both institutional and non-institutional long-term care (e.g., nursing home care, home health services) was typically provided by Medicaid programs in the fee-for-service setting rather than through managed care arrangements. Such was also the case for dental services. In early 2000, the GAO conducted a study examining factors contributing to the low use of dental services by low-income populations.¹⁰ In that study, GAO determined that 20 states used managed care to provide some dental services to Medicaid beneficiaries. More recent data from CMS show that, as of June 30, 2006, 32 states had managed care arrangements that included coverage of dental services.¹¹

The Domestic Policy Subcommittee of the House Oversight and Government Reform Committee requested that CRS analyze dental claims data from selected managed care plans in three study states – Arizona, New Jersey, and Pennsylvania. Statewide and county-specific claims data for the AmeriChoice Managed Care Organization (MCO) were available for Arizona (statewide and Apache County), New Jersey (statewide and Essex County), and Pennsylvania (statewide and Philadelphia County). Additional claims data were available for the AmeriGroup MCO in Essex County, New Jersey, the Keystone MCO in Philadelphia County, Pennsylvania, and the HealthChoice MCO in Apache County, Arizona. These data allowed for the comparison of two different MCOs operating in the same county in three distinct parts of the nation.

The Subcommittee asked CRS to look at two aspects of Medicaid dental services:

- What share of MCO enrollees did not receive dental services, despite multiple years of MCO enrollment?
- How many providers in each county actually delivered services to enrollees (as measured by the number of Medicaid paid claims processed by the MCO in fiscal year 2006)? In particular, is there a concentration of providers that actively deliver services in these particular counties?

⁹ See, for example, S. Gehshan and M. Wyatt, *Improving Oral Health Care for Young Children*, National Academy for State Health Policy, April 2007, and A. Borchgrevink, A. Snyder, and S. Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, National Academy for State Health Policy, March, 2008.

¹⁰ The General Accounting Office (GAO), *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149, September, 2000.

¹¹ See Centers for Medicare and Medicaid Services, *2006 National Summary of State Medicaid Managed Care Programs: Program Descriptions as of June 30, 2006* (pages 653 - 654) at <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/nationalsummreport06.pdf>.

Claims Data – Findings on Receipt of Dental Services Among Children in Selected Managed Care Plans in the Three Study Areas

Table 1 provides an analysis of the number of enrollees in each of the study areas who: (a) were continuously enrolled in the MCO beyond a single year, and (b) the number who did not receive any dental services. In general, the longer a child was enrolled in a MCO, the higher the likelihood that the child had some dental services paid for by the MCO in all three of the study states, regardless of the specific MCO. Also, despite continuous enrollment over multiple years, a large share of children enrolled in any of the study MCOs did not have a dental service claim paid by the MCO during the study period. For example, during three years of continuous enrollment, between 30 and 40 percent of enrollees had no paid dental claims in the three study sites. The accompanying **chart** provides a comparison of each of the study sites and MCOs, taking into account different time periods of continuous coverage.

It should be noted that these estimates are based on enrollees with paid dental service claims. In some instances, individual members may have received dental services outside of the MCO or received dental services without generating a paid claim. Such services were not captured in these estimates.

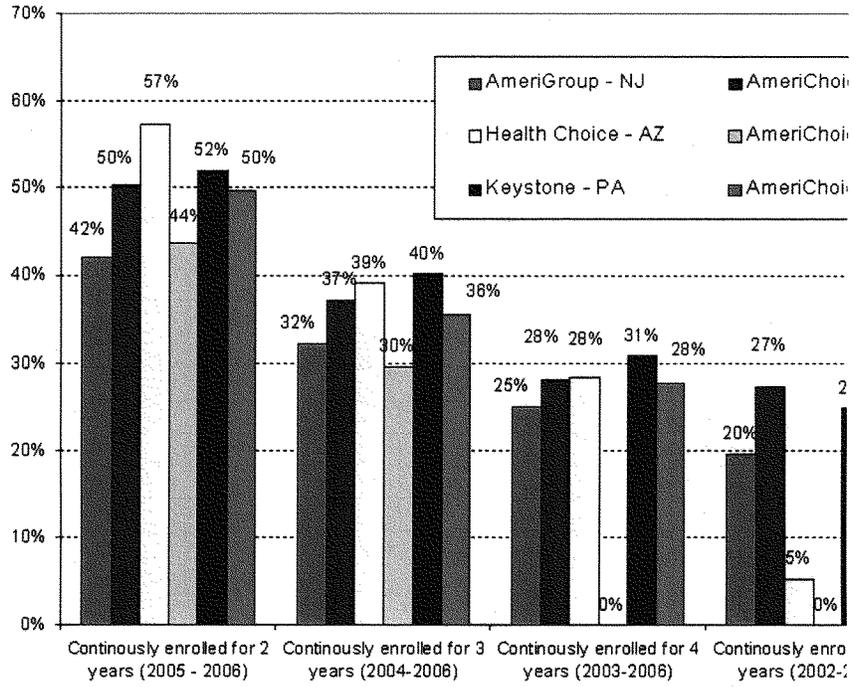
Table 1. Comparison of the Number of Enrollees with No Paid Claims in Selected Medicaid Managed Care Organizations, 2002 - 2006

Years of Enrollment	Total Enrollees	Number of Enrollees with No Paid Dental Claims	Percent of Enrollees with No Paid Dental Claims
Apache Arizona – HealthChoice			
2005 - 2006	69,433	39,841	57%
2004-2006	46,091	18,053	39%
2003-2006	31,483	8,948	28%
2002-2006	17,786	950	5%
Apache Arizona - AmeriGroup			
2005 - 2006	186,287	81,314	44%
2004-2006	141,565	41,949	30%
2003-2006	111,442	69	0%
2002-2006	80,093	0	0%
AmeriGroup – Essex New Jersey			
2005 - 2006	54,975	23,146	42%
2004-2006	35,392	11,436	32%
2003-2006	22,905	5,715	25%

CRS-5

Years of Enrollment	Total Enrollees	Number of Enrollees with No Paid Dental Claims	Percent of Enrollees with No Paid Dental Claims
2002-2006	14,164	2,781	20%
AmeriChoice – Essex New Jersey			
2005 - 2006	134,766	67,978	50%
2004-2006	102,178	37,982	37%
2003-2006	79,344	22,231	28%
2002-2006	56,319	15,394	27%
Keystone Mercy – Philadelphia Pennsylvania			
2005 - 2006	183,903	95,509	52%
2004-2006	144,970	58,314	40%
2003-2006	113,008	34,947	31%
2002-2006	91,208	22,651	25%
AmeriChoice – Philadelphia Pennsylvania			
2005 - 2006	56,307	27,989	50%
2004-2006	44,879	16,005	36%
2003-2006	36,993	10,225	28%
2002-2006	30,115	6,976	23%

Share of Enrollees with No Dental Service over Selected Time Periods



Claims Data – Findings on Provider Concentration in Selected Managed Care Plans in Three States

Table 2 provides summary information on the number of providers with paid claims, the number of providers with 10 or more claims, the number of providers with more than 50% of the paid claims, and the total number of paid claims.

Table 2. Selected Provider Characteristics Among Four Medicaid Managed Care Organizations, 2006

Managed Care Organization	Number of providers with paid claims	Number of providers with 10 or more claims	Number of providers that represent more than 50 percent of claims	Total number of paid claims
HealthChoice - Apache Arizona	21	4	2	312
AmeriChoice -- Appache Arizona	76	15	3	2,254
AmeriGroup - Essex New Jersey	59	50	10	5,293
AmeriChoice - Essex New Jersey	203	88	9	16,404
Keystone Mercy -- Philadelphia Pa.	160	130	4	92,493
AmeriChoice -- Philadelphia Pa.	177	136	8	38,160

The number of providers with at least one paid claim in the three study localities varies from a low of 21 providers with paid claims in Apache County, Arizona to 203 providers in Essex County, New Jersey. Variation in the number of providers with paid claims is not surprising; the population of eligible children varies dramatically from one locale to another. For instance, in 2006, the average monthly enrollment in Apache County, Arizona, for the HealthChoice MCO equaled 820 children (the average monthly enrollment for AmeriChoice in the same county equaled 1,932); the average monthly enrollment in Essex County, New Jersey, for AmeriChoice equaled 20,597 (the comparable figure for AmeriGroup in the same county equaled 9,125). There is no simple measure of the adequacy of a provider network. However, these data suggest that there is substantial variation in the number of providers with paid claims relative to the number of enrollees in each of the MCOs.

Another measure to consider in determining the adequacy of a dental provider network is to determine the distribution of paid claims among participating providers. There are numerous reasons why this is a crude measure of network adequacy. For example, this measure does not consider how easy it is to schedule an appointment and then to actually get to the provider and receive dental services. In addition, some Medicaid beneficiaries may have special needs and may be best seen by providers with special training, equipment and experience treating such patients. For example, in Philadelphia, *Special Smiles Limited* is dedicated to providing dental services for children and adults with special needs. The dentists at this facility provide a large amount of care in both Medicaid managed care organizations in the Philadelphia study area.

These limitations being recognized, there is a consistent pattern across all the study MCOs in this analysis. In all instances, a relative small number of providers account for a large share of the

paid dental claims. For example, in the Keystone Mercy MCO in Philadelphia, 4 of 160 providers accounted for more than 50% of paid claims. Likewise, in the AmeriGroup MCO in Essex County, New Jersey, 10 of 59 providers accounted for more than 50% of paid claims.

CMS-416 Data – State-Level Findings on Receipt of Dental Services Among EPSDT Participants

The Medicaid statute (Section 1902(a)(43)) requires states to inform and arrange for the delivery of EPSDT services to eligible children, and also includes annual reporting requirements for states. Among several requirements, states must report the number of children receiving dental services. The tool used to capture these required EPSDT data is called the CMS-416 form. The current CMS-416 form (effective as of FY1999) includes the unduplicated count of EPSDT eligibles by age and basis of eligibility who receive (1) any dental services, (2) preventive dental services, and (3) dental treatment services. Classification into one of these measures is based on specific dental procedure codes recorded on provider claims.

Tables 3 - 5 show receipt of dental services among EPSDT eligibles in the three study states, and other reporting states combined, for FY2006.

Receipt of Any Dental Services. For all children under age 21, the three study states combined had a somewhat lower proportion receiving any dental services (29%) compared to all other reporting states combined (33%), as shown in **Table 3**. Across age groups, children ages 6 to 9 years had the highest rates of receiving any dental services, ranging from 36% to 54% among the three study states, compared to 47% for all other reporting states combined. The higher rates of dental care receipt among this age group may be related to school entry, since young children are typically required to be up-to-date on certain immunizations to attend school. As a part of those immunization visits, physicians may also make references for dental care for these children.

Table 3. Percentage of EPSDT Eligibles Receiving Any Dental Services by Age Group, FY2006

States	Total	Under 1	1 - 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
AZ	33.6	0.1	7.7	41.4	54.1	47.2	32.1	17.8
NJ	25.9	0.5	5.3	27.8	35.9	34.8	30.9	21.3
PA	27.2	0.1	4.9	30.7	38.3	35.1	30.4	19.9
Study States Combined	28.6	0.2	5.9	33.1	42.1	38.0	30.9	19.8
Other Reporting States	33.1	0.8	13.3	39.5	46.8	42.7	34.2	20.5
Total Reporting States	32.8	0.7	12.7	39.0	46.4	42.4	34.0	20.4

Source: FY2006 CMS-416 reports, provided to CRS as of August, 28, 2008. Data for Kentucky, Maine and Vermont were not available, and thus, these states are excluded from these analyses.

Receipt of Preventive Dental Services. One of the three study states – Arizona (28%) – had rates for preventive dental care among all children under 21 that were the same as or better than the 28% average for all other reporting states combined (see **Table 4**). Again, the percentage of children receiving preventive dental services was highest among the 6 to 9 year old age group compared to other age groups.

While none of the three study states reached the 57% participation goal for preventive dental care among children established in *Health People 2010*, Arizona was closest for the subgroup between the ages of 6 and 9. Among the other reporting states, two exceeded this goal for children ages 6 to 9 years – Nebraska and South Carolina (57.9% and 65.1%, respectively; data not shown).

Table 4. Percentage of EPSDT Eligibles Receiving Preventive Dental Services by Age Group, FY2006

States	Total	Under 1	1 to 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
AZ	28.0	0.0	3.3	33.4	48.5	41.9	25.1	10.4
NJ	21.2	0.1	4.2	24.4	31.6	28.7	21.5	12.4
PA	22.6	0.0	2.6	25.0	34.3	30.8	23.8	13.1
Study States Combined	23.7	0.0	3.2	27.4	37.5	33.0	23.5	12.4
Other Reporting States	28.1	0.4	9.8	34.2	41.8	37.3	26.9	13.7
Total Reporting States	27.7	0.4	9.3	33.7	41.5	37.0	26.7	13.6

Source: FY2006 CMS-416 reports, provided to CRS as of August, 28, 2008. Data for Kentucky, Maine and Vermont were not available, and thus, these states are excluded from these analyses.

Receipt of Dental Treatment Services. The data patterns for receipt of dental treatment services (see **Table 5**) are similar to those described above for receipt of any and preventive dental services among children under 21. These data do not account for the need for dental treatment, only whether or not such treatment was provided. In general, fewer children receive dental treatment services than receive preventive dental care.

Table 5. Percentage of EPSDT Eligibles Receiving Dental Treatment Services by Age Group, FY2006

States	Total	Under 1	1 to 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
AZ	18.2	0.1	2.3	21.0	31.4	25.2	18.7	10.7
NJ	15.3	0.1	1.9	13.5	21.3	21.4	20.6	14.6
PA	13.1	0.0	1.3	10.9	18.8	17.4	17.0	12.5

CRS-10

Study States Combined	15.0	0.1	1.7	14.6	23.0	20.3	18.2	12.5
Other Reporting States	17.6	0.1	2.6	17.3	26.3	23.9	21.7	13.3
Total Reporting States	17.4	0.1	2.5	17.3	26.1	23.7	21.5	13.2

Source: FY2006 CMS-416 reports, provided to CRS as of August, 28, 2008. Data for Kentucky, Maine and Vermont were not available, and thus, these states are excluded from these analyses.

Conclusions

While progress has been made by states to provide dental services to Medicaid children, recent statistics indicate that more work needs to be done in this area. States with higher levels of dental care among Medicaid children may be able to provide guidance on their successes and failures to other states with lower levels of dental care. A parallel effort across Medicaid managed care plans may also be fruitful. Such efforts could be organized and facilitated by various federal agencies, including, for example, CMS, Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), and the National Institute of Dental and Craniofacial Research.

Mr. KUCINICH. At this time I recognize the ranking member, who has worked with us throughout this entire matter, Mr. Issa of California. Thank you, sir, for being here.

Mr. ISSA. Thank you, Mr. Chairman.

Mr. Chairman, this is the fourth in a series of hearings. Unlike some of the hearings that often occur, not just in this committee but in other committees, where you have a hearing, you play "gotcha," and then you move on, you have steadfastly stood to try to not only bring awareness to this problem, but, in fact, to go beyond that to bring and oversee changes.

These hearings were, of course, first prompted by the tragic death and avoidable death of Deamonte Driver, who died of a brain infection as a result of tooth decay.

Mr. Chairman, I appreciate your efforts to prevent any event like this from happening in the future. It is very clear that, of all the areas of medical coverage that America does the least well, it is dentistry, not because we don't have the finest dentists or the finest dentistry in the world—we do, we lead the world—but programs such as Medicaid, which often talk in terms of preventative activities, certainly do a fine job on vaccines, but they fail to hit the most important part of the responsibility. Poor oral health is a leading cause of so many other diseases and, of course, leads to a lifelong inability to be healthy and to regain that health.

Mr. Chairman, the fact that you have made it your mission to go after failures of Medicaid and CMS, failures to oversee the States who have the primary responsibility—as we both know, dentistry is not an entitlement, but where, in fact, States have agreed to do it, the Federal Government is a full partner in that. We need to make sure that is being delivered properly.

As you said in your opening statement, it is very, very clear that just having a program is not of any value if you have no access because of an insufficient number of dentists available. Dentists react to the market faster than any other part of medicine. Dentists will immediately recognize if we are not paying a sufficient amount or not authorizing services for those they need. Dentists are, in fact, small businessmen, for the most part, and, unlike physicians, they can't rely on a hospital or other offsets.

A dentist who is particularly pediatric and operates in a poor area or under-served area is going to find himself with patients who can't pay that he is trying to finance, patients who seek Medicaid, and a relatively small amount of patients who have full dental coverage.

Mr. Chairman, your work has prompted the GAO report being released today, which will be discussed in the first panel, but which, in fact, is an opportunity for you and I together and others in Congress to take this challenge, which has not yet been met, into the next Congress.

I look forward to the briefing here today.

I also would like to thank you for the invitation you placed to the American Dental Association. You and I both know that Government has often failed to go to those who have the expertise and say, why is it we are failing? Why is it that dentists often choose not to take Medicaid patients? Today we are going to have an opportunity to see and hear what is still wrong, what has been im-

proved, and, equally importantly, to talk to the professionals who we have to make future programs, both at the Federal and State level and particularly Medicaid, fit their needs or we will not have full access to coverage.

Mr. Chairman, often one person gives their life and becomes a poster child for people to complain about the system. In this case you have done a great job, and I would like to commend you as we near the end of Congress, for using that tragic loss to bringing about permanent and profound change.

I look forward to, for the rest of this Congress and into the next Congress, working with you on a bipartisan basis to find solutions that work for the children who today are not getting the dental care that will lead to a healthy adult life.

I yield back and thank the chairman for his leadership.

Mr. KUCINICH. I want to thank the ranking member. For those of you who may not be aware of it, Mr. Issa and I both hail from Cleveland, although I am privileged to represent it in the Congress. Mr. Issa and I both understand from our childhood experiences the relevance of this pediatric dental issue. When you know that personally, you understand and become very involved in a way that can be constructive.

So I want to say that the progress that we have been able to have here could not have happened without your participation and your support, because when you have a committee work and something gets done, it is not just one person that brings it about; you have to have a partner on it. Mr. Issa has been a terrific partner on these things, so I want to thank you as we move forward.

I also want to recognize our staff of the subcommittee, because without it we wouldn't be able to get into the depth that we have been able to get into. There is still a long way to go, but we have had some progress.

Let's start by introducing the first panel.

Mr. Herb Kuhn is the acting director of the Center for Medicaid and State Operations. He is a nationally recognized expert on value-based purchasing and payment policy. Mr. Kuhn most recently served as director for the Center of Medicaid Management. As CMM director, Mr. Kuhn oversaw the development of regulations and reimbursement policies for the fee-for-service portion of Medicare, covering the universe of providers that care for 43 million elderly and disabled Americans under Medicare.

Ms. Alicia Puente Cackley is an Acting Director at the U.S. Government Accountability Office. She currently directs several teams of analysts doing health policy research, including studies of Medicaid services for children and adults, and immigrant detainee health. Prior to joining the health care team, Ms. Cackley worked in GAO's education work force and income security team, where she managed teams analyzing Social Security reform, retirement and aging issues, as well as work force immigration issues.

I want to thank you both for appearing before our subcommittee today.

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

[Witnesses sworn.]

Mr. KUCINICH. Let the record show that the witnesses have answered in the affirmative.

I would ask each of the witnesses to now give a brief summary of their testimony, and to keep the summary under 5 minutes in duration. Bear in mind your complete written statement will be included in the hearing record.

I want to thank Mr. Higgins from New York for joining us.

Mr. Kuhn, let's begin with you.

STATEMENTS OF HERB KUHN, ACTING DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS; AND ALICIA CACKLEY, ACTING DIRECTOR, HEALTH CARE TEAM, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF HERB KUHN

Mr. KUHN. Good morning, Chairman Kucinich and members of the subcommittee. Thank you for inviting me to discuss pediatric dental care under Medicaid.

CMS shares this subcommittee's conviction that we must improve dental care services for children with Medicaid. As I have personally shared with Chairman Kucinich, our agency is grateful for this subcommittee's leadership in this area. You have provided us with helpful information as we move forward on our efforts to improve care. In this regard, I wanted to take my time today to give you an update on where we are with our investigations and improvement efforts.

First, CMS has completed its onsite reviews of 17 State dental programs. The States targeted for review were those States where less than 30 percent of the children on Medicaid were seen by a dentist in the previous year. CMS used 2006 as the benchmark year. When these reviews are completed, we plan to host a national town hall meeting to discuss our findings and ask for suggestions on policy options to improve the utilization of dental care for these vulnerable children.

Once we complete the national town hall meeting, we plan to share our report through a State Medicaid director's letter to all States and the District of Columbia. We intend to complete this entire process by the end of this year.

I want to assure the committee that we are not waiting to take actions with States on issues that are identified, however, during these reviews. Once each State review is completed, we are making a set of recommendations for each State and are initiating compliance actions on those recommendations.

Second, CMS has asked all States to update and submit to us their dental periodicity schedules for review. As part of our review, we have found that some States were out of compliance with CMS requirements. Even more unfortunate, some States have still not responded to our request for these oral health schedules. Some of those States are represented by members on this subcommittee.

We have shared with you the list of States that still have not provided us with these oral health schedules. As part of our ongoing partnership with this subcommittee on the Medicaid dental program, I would appreciate your assistance in contacting your own State to help us obtain those schedules.

Third, in collaboration with the National Association of State Medicaid Directors, we have developed an oral health technical advisory group. They helped us update the policy questions and answers that you had inquired about, as well as helping us with improvements in the annual EPSDT reporting form. We all know we need to capture better data on dental services, and we are hopeful that by improving this reporting form it will help us identify areas of weaknesses on which we can focus our attention.

We also are including dental activities in our State quality assessment reports, and we are working with the American Dental Association to create a dental quality alliance to help us develop evidence-based performance measures.

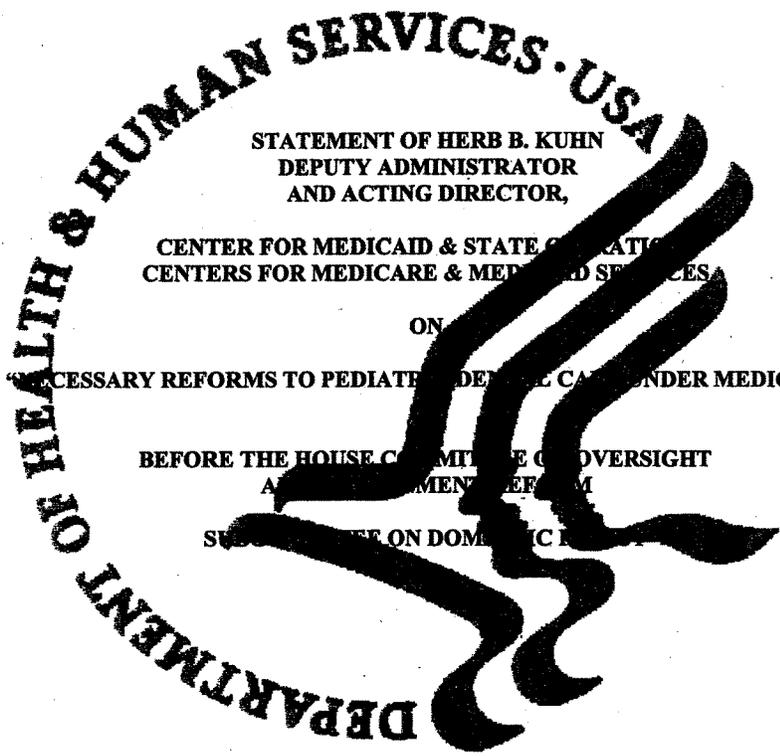
Fourth, we have moved forward with the States on sharing best practices, convening a national call to discuss innovative State programs. I am excited about the growing collaborations that we are seeing in various events, including the National Oral Health Conference.

Finally, I would like to share with the subcommittee that, since assuming the role as Acting Director of the Center for Medicaid and State Operations, I have met with State Medicaid Directors and discussed this issue at length. Furthermore, CMS staff have been in contact with every State, from State Medicaid directors to State dental officers to discuss these issues. I can assure you that every State understands the additional scrutiny we are putting them under.

While our work is far from done, I am confident that we are moving in the right direction and look forward to continuing to work with this subcommittee and others on improved pediatric dental care.

I would be happy to answer your questions.

[The prepared statement of Mr. Kuhn follows:]



STATEMENT OF HERB B. KUHN
DEPUTY ADMINISTRATOR
AND ACTING DIRECTOR,

CENTER FOR MEDICAID & STATE OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"NECESSARY REFORMS TO PEDIATRIC DENTAL CARE UNDER MEDICAID"

BEFORE THE HOUSE COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM

SUBCOMMITTEE ON DOMESTIC POLICY

September 23, 2008

Testimony of Herb B. Kuhn

**Deputy Administrator and
Acting Director,
Center for Medicaid & State Operations
Centers for Medicare & Medicaid Services**

**on
Necessary Reforms to Pediatric Dental Care under Medicaid
Before the
House Committee on Oversight & Government Reform
Subcommittee on Domestic Policy**

September 23, 2008

Good morning Chairman Kucinich and members of the Subcommittee. Thank you for the opportunity to provide an update on the initiatives the Centers for Medicare & Medicaid Services (CMS) has taken with regard to dental care for children served by the Medicaid program.

As you know, Medicaid is a shared partnership between the Federal Government and the States that will provide more than \$368 billion in medical services in Fiscal Year (FY) 2009. Although the Federal Government provides financial matching payments to the States, each State designs and runs its own program within the Federal structure and is responsible for administering its Medicaid program. The States enroll providers, set reimbursement rates, and negotiate managed care contracts. CMS works with State Medicaid agencies to encourage quality care, adequate access, and appropriate use of Federal Medicaid matching funds.

It is CMS' goal to protect Medicaid's integrity, promote efficient operations, and ensure safe and quality health care for all recipients. In this manner, there have been a number of important developments for improving oral health since my predecessor's testimony before you in February 2008. Specifically, I will discuss the reviews we have conducted, outreach we have made, and assessments we have provided to the States.

CMS Response to Improving Oral Health

As noted earlier, States administer the Medicaid Program with general oversight from CMS. As such, CMS is committed to working with the States to improve oral health. CMS seeks to support States in their efforts to improve services through interventions focused in three strategic areas: improved access to required dental services, reimbursement aligned with desired outcomes, and attention to the quality and transparency of dental services provided. However, because, by design, each State's program is unique and targeted to the population served and because there are several barriers, identified by the Centers for Disease Control (CDC), to receiving dental care, there is no one single activity that can be implemented to stimulate improvement. Improving oral health requires a robust process which looks at the unique attributes of each State's program.

As a result, CMS completed 17 State dental reviews in the past seven months to assist us in obtaining data on these three strategic areas to improve oral health. The findings from these reviews will be summarized in a national report and used to inform future policy and improvement activities in the three strategic areas.

Status of CMS Focused Dental Reviews

The States CMS targeted for review were primarily those that reported a thirty percent or less dental services utilization rate for children receiving Medicaid, as reported on the 2006 CMS-416 forms. CMS also reviewed an additional State that had a higher utilization rate of thirty-six percent, but which raised concerns related to the implementation of that States' managed care program.

The purpose of the reviews was to determine what efforts each State had made to address the issue of dental underutilization for children in that State and to make recommendations on additional steps the State should take to increase these utilization rates. Specifically, the CMS review team interviewed State officials, contractors, managed care organizations, as well as a sample of providers. The review team also conducted extensive document review in the areas of outreach periodicity, access, diagnosis and treatment services, support services, and coordination

of care. Additionally, the Center for Medicaid & State Operations (CMSO) reviewed information collected from families of children covered by Medicaid.

Following these reviews, draft reports were completed for every State that was reviewed. Four reports have been finalized and released (MD, ND, AR, and MT) and 7 additional draft reports have been sent for comments to the respective States. In addition to finalizing the remaining reports, CMS is currently analyzing the report findings to prepare a National Summary of the dental reviews. While the comment period has not been completed for some States, CMS has already identified certain trends that will be discussed in the National Summary Report. In short, CMS observed that States with lower utilization of children's dental services frequently required improvements in the following areas:

- Clear information for beneficiaries that was linguistically and culturally appropriate regarding the availability and importance of dental services and how to access the services;
- Process to remind beneficiaries that recommended visits were due;
- Updated dental provider listings;
- Process to track whether recommended visits occurred;
- Availability of dental providers, particularly in more rural portions of the State;
- Availability of specialists for referrals; and
- Availability and reliability of transportation to dental services.

Providers frequently offered the following barriers to their participation as a Medicaid Provider:

- Low reimbursement rates;
- Missed appointments without the ability to recoup a "no show" fee;
- Burdensome prior authorization processes; and
- Rejection of claims without a satisfactory explanation.

Additionally, CMS reviewed data from the National Health and Nutrition Examination Survey (NHANES) collected by the CDC on the barriers to receiving children's dental services, as reported by families. The reasons the families most frequently cited as barriers included:

- The belief that they cannot afford dental care;

- Problems obtaining approval for care;
- The provider's refusal of their insurance plan; and
- Not knowing where to go to get care.

Also, CMS plans to further evaluate several promising practices we identified, such as:

- Streamlined administrative processes;
- Use of mobile dental services; and
- Collaborations with Head Start or other public health programs.

After completing the final reports, CMS will develop additional strategies and policy options that can help support States in their efforts to address the issues identified. CMS will also convene a town hall meeting to discuss the National Summary Report and policy options, as well as convene Medicaid recipient focus groups. Finally, based on the findings from the final reports, CMS will require corrective actions for those States not in compliance with Federal Regulations.

Periodicity Schedule Reviews

In addition to the 17 State focused reviews, CMS collected information on the availability of Dental Periodicity Schedules from all 50 States and the District of Columbia. Our initial review indicated that all but three States reported having some type of periodicity schedule, although they were not all in compliance with the CMS requirements. For example, some of the schedules provide a timeframe for when a primary care physician should refer the child for a service, but did not specifically address how often the actual dental service should occur. Additionally, CMS found that several of the periodicity schedules were not easily accessible by providers and beneficiaries.

As a result, the CMS Regional Offices contacted all the States outlining the expectations of an oral health schedule that is separate and distinct from the general health screening schedule. We noted that the schedule should be developed in consultation with recognized dental organizations involved in child dental health care. States were instructed to provide these schedules to CMS by September 1, 2008. As of this date, 38 States have provided acceptable periodicity schedules

and 7 other submissions were found to have insufficient information. Some States reported that they were still working with their professional societies, while others have not responded to the initial request. The CMS Central Office has contacted the States that have not responded to inform them that it is our expectation that they adopt the periodicity schedule recommended by the American Academy of Pediatric Dentistry, if they cannot provide us with an approved schedule by October 15, 2008.

Other CMS Activities

In addition to the reviews, CMS is working on a number of other activities in coordination with the States to improve access to quality dental care for Medicaid eligible children. Some of the actions that we have taken include the following:

- In collaboration with the National Association of State Medicaid Directors, CMS developed an Oral Health Technical Advisory Group (TAG) and has held four meetings to date. The TAG is currently working on revising the policy paper on dental questions and answers that this Subcommittee inquired about during the February 2008 hearing. The paper is currently in the final stages of review and we plan to have it published on our website by the end of the month. The TAG is also considering improvements to the CMS-416, the annual EPSDT reporting form, to determine if we can better capture the array of oral health services that are being delivered in different settings. During our last TAG call we began to address the issue of improving the materials used to inform beneficiaries of the dental services they can receive under Medicaid.
- In addition to the TAG, we have received information from the American Dental Association (ADA) regarding the formation of a Dental Quality Alliance (DQA). The ADA Board of Trustees has indicated a willingness to explore this Alliance with its House of Delegates at its meeting in mid-October. These efforts require collaboration across all parties involved with healthcare. One goal of the Alliance will be to bring about consensus in the area of evidence-based performance indicators that can be used to measure improvements in access and quality consistently throughout the country.

- Additionally, the Director of the Medicaid Quality Division of the CMS CMSO and the CMS Chief Dental Officer have met with the American Academy of Pediatric Dentistry and the Medicaid and SCHIP Dental Association. As a result of these actions, they served as featured presenters at the National Oral Health Conference that was held April 28-30, 2008. This conference was sponsored by the American Association of Public Health Dentistry and the Association of State and Territorial Dental Directors. This presented 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. The American Academy of Pediatrics is also sponsoring an Oral Health Conference this fall.
- We have also worked to share innovative practices directly with the States. Our spring 2008 Quality Teleconference Call held on April 3, 2008 focused on promising practices in children's dental care. The Conference included presentations on innovative approaches to financing dental care, including information from the State of North Carolina on its "Into the Mouth of Babes" program, the State of Tennessee's approach to increasing provider participation and access, the State of Michigan's Healthy Kids Dental program and the State of California's proposed dental performance measures for their SCHIP population. The conference call was well received and there were over 400 participants.
- We also have several dental "promising practices," including some from the 2008 Quality Teleconference Call, on the CMS website and are continuing to work with other States to disseminate information regarding their programs. Additionally, earlier this month we funded a contract to explore child health promising practices in Medicaid and SCHIP in nine States. Although only nine States will be involved in the project, we may receive multiple promising practices from a State. This contract ends in December and we hope a final report will be available early next year.
- 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. To date, we have completed eight Quality Assessment Reports. Feedback from the States has been very positive and they have indicated that this report will serve them well as a tool in their quality improvement efforts. Some States have actually requested that they be next in line to receive a quality assessment.

- We continue to hold regular meetings with all the Regional Office EPSDT/Dental Coordinators to discuss various child health activities including the importance of providing technical assistance to and oversight of States in the area of CMS-416 reporting for EPSDT and dental services. We are working aggressively to ensure the accurate 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. We have received 2006 data from all but one State. We are working with the one State, which continues to have problems with the accuracy of its data. The 2007 data was due on April 2008. We have received data from all but five States and we continue to work with these States on their submissions. We also continue to explore additional avenues of data collection. This month we funded a contract that will focus on helping many Medicaid Managed Care Organizations collect quality performance information in a consistent manner, so as to allow for benchmarking on various quality measures with plans across the country. We are also working with the National Committee on Quality Assurance on child health measures, reviewing existing measures and new measures that have a preventive care focus.

States Response to Improving Oral Health

While CMS support is important, real change in the system occurs at the local level by State administrators, local providers and their patients. The Oral Health TAG has been very helpful in identifying successful State practices. Following are some examples of actions States have taken to improve oral health services.

Maryland

As the Subcommittee is aware, Maryland formed a Dental Action Committee that developed a Dental Action Plan that was submitted to the State's General Assembly, which ultimately is responsible for providing the necessary funding to support the recommendations for increased reimbursement. The General Assembly approved many components of the plan and Maryland is in the process of implementation. CMS regional office staff conducts regular monitoring of the progress in the State of Maryland. The State highlights the following activities as recent accomplishments:

- The State developed and issued a request for proposals (RFP) for a single statewide vendor to coordinate and administer dental benefits for Maryland Medicaid beneficiaries. This will require the State 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 (ASO). Maryland expects this change to be implemented by July 2009. The long-term goal will be to ensure that every child with Medicaid coverage has access to a dental home. We understand the bids are currently under review by the State.
- The Maryland Governor's FY 2009 budget included \$14 million as 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 critical in attracting additional providers. The first year of the fee increase was approved by the Maryland General Assembly and was implemented on July 1, 2008. The first codes to be targeted for increases were diagnostic and preventive codes which were poorly paid in the past, but should now compare very favorably with other state rates.
- The Maryland Governor's budget included new funds to enhance the dental public health infrastructure. These funds will help establish new dental public health clinics in the southern and eastern shore regions of Maryland where there are no existing dental public health facilities. Further, these funds will be used to increase operational support for existing local health department dental clinics thereby increasing access to oral health services for low-income children statewide. 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.

- The State passed legislation during the last legislative session to allow for an increased scope of practice for public health dental hygienists in Maryland. This will help provide preventive services, such as fluoride varnish, to more children with Medicaid coverage.

Vermont

Vermont has implemented a “Dental Dozen” Initiative which is a comprehensive program for State Fiscal Year 2008 and beyond. The Dental Dozen outlines 12 targeted initiatives to improve oral health for all Vermont residents. The initiative includes such items as reimbursing primary care physicians for oral health risk assessments, increasing dental reimbursement rates, placing dental hygienists in each of the 12 district health offices, collecting data on missed appointments, and several other payment incentives.

Pennsylvania

Pennsylvania has embarked upon targeted fee increases for select dental preventive services and treatments. This includes several significant increases in July 2008 for restorations, endodontics, crowns, extractions, and orthodontics in support of the Dental Disease Management Program. The State has also revamped its prior authorization process, based on historical data, so that selected dental services, which provide little financial risk, no longer require prior authorization. Also in 2008, Pennsylvania modified their managed care contract to include pay-for-performance and performance improvement projects in priority dental topic areas. They have also increased their outreach activities.

Tennessee

Tennessee was one of the first States to carve-out its Medicaid Dental Program, separating it out from other managed care services. They also hired their first Medicaid Dental Director to provide oversight of the program and established a Dental Advisory Committee. Over the past six years Tennessee notes a 129 percent increase in the dental provider network, a 43 percent

increase in utilization by enrollees, intensive outreach to encourage member participation and the collaboration of key stakeholders including organized dentistry.

Alabama

The Alabama Medicaid Agency has successfully worked with the Alabama Chapter of the American Academy of Pediatrics and the Alabama Academy of Pediatric Dentistry to add coverage of oral health risk assessment and fluoride varnishing in the pediatric medical home for children from six months to three years of age. The program will be called First Look and will be effective January 1, 2009. This collaborative effort will be utilized to revise and expand the First Look Project that was originally developed in 2004, where pediatric primary care providers were provided with resource information and guidelines to assess their patients and provide appropriate guidance to the families. Additionally, in January 2007 the State added procedure codes to encourage providers to see patients before the age of 3. They continue to make detailed changes on a quarterly basis within the Dental Chapter of the Alabama Medicaid provider manual to encourage quality of care by the providers.

Connecticut

Effective April 1, 2008, Connecticut increased pediatric dental fees by \$20 million. They also provided \$4 million in grants to safety net providers to expand access. The State carved out dental services to a non-risk Administrative Service Organization effective January 2008 and increased their dental provider panel by more than 100 percent. They have now dedicated \$250,000 to a contract to expand outreach to providers.

Conclusion

CMS continues to make strides in engaging the States to make joint efforts to expand the use of dental services among Medicaid children and in our ability to report such progress to the public. As noted above, CMS is working on a number of activities in coordination with the States and we are continually considering initiatives to improve. Upon the conclusion of our National Summary Report, which will summarize the findings and trends from the focused State reviews, we anticipate developing a plan of action that will further the objectives of improved access to required dental services, reimbursement aligned with desired outcomes, and attention to the quality and transparency of services provided. We know 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. I thank the gentleman.
The gentlelady may proceed.

STATEMENT OF ALICIA CACKLEY

Ms. CACKLEY. Mr. Chairman, Ranking Member Issa, members of the subcommittee, I am pleased to be with you today as you examine reform to pediatric care and Medicaid. This is an issue this committee has been focused on for some time, since the tragic death of Deamonte Driver.

My comments this morning are based on a report we prepared for the subcommittee, which you are releasing today, entitled, "Medicaid: Extensive Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay."

My remarks will cover three key questions that you asked us to investigate: the extent to which children in Medicaid experience dental disease, the extent of dental care they receive, and how these conditions have changed over time.

In summary, dental disease and inadequate receipt of dental care remains a significant problem for children in Medicaid across the country. Our analysis of national data indicates that approximately one in three children on Medicaid age 2 through 18 had untreated tooth decay, and 1 in 9 had untreated decay in more than three teeth.

Projecting these percentages on 2005 Medicaid enrollment levels, we estimate that 6.5 million children in Medicaid have had untreated tooth decay. This rate of dental disease for children in Medicaid was nearly double the rate for children who had private insurance, and very similar to the rate of children who are uninsured.

Turning to national data on receipt of dental care, we found that nearly two in three children in Medicaid had not received any dental care. Again, projecting these percentages on 2005 enrollment levels, we estimate that 12.6 million children in Medicaid didn't see a dentist in the previous year.

In addition, the data show that only about one in eight children ever see a dentist.

As you may know, HHS has national health goals known as Healthy People 2010, which include the target of having two-thirds of low-income children receive a preventive dental service in a given year. Our analysis shows that as a nation we are way behind, since we found that only one-third of children in Medicaid received any dental care in the previous year.

Looking over time, there is some good news to share with you. Comparisons of past and more recent survey data suggest that indicators of receipt of dental care, including the proportion of children who had received dental care in the past year and the proportion who had received dental sealants have shown some improvements over time. The percentage of children in Medicaid who received dental care in the previous year increased from 31 to 37 percent over approximately 10 years.

In addition, the percentage of slightly older children, whose aged 6 through 18 with at least one dental sealant increased nearly three-fold.

Despite these improvements, however, we found that rates of untreated tooth decay for children and Medicaid were largely unchanged. We look at data around two time periods around the early 1990's and compared it to the early 2000's. The proportion of children in Medicaid who experienced tooth decay, both treated and untreated, actually increased from 56 percent to 62 percent over this time period.

In conclusion, the information provided by these national surveys regarding the oral health of our Nation's children on Medicaid raises serious concerns. Measures of access for dental care for this population remained far below our national health goals.

Of even greater concern are data showing that dental disease is prevalent among children on Medicaid and is not decreasing over time. Millions of children on Medicaid are estimated to have dental disease and be treated. In many cases, this need is urgent.

Given these conditions, it is important for all those involved in providing dental care to children in Medicaid, the Federal Government, States, providers, and others, to continue working to improve the oral health condition of these children and achieve stated national oral health goals.

I am not making specific recommendations today, but expect to have more information for you once we have completed our ongoing work for this subcommittee. This work includes reviewing both State Medicaid programs and CMS's efforts to monitor and ensure the children in Medicaid receive recommended dental services.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to questions.

[The prepared statement of Ms. Cackley follows:]

United States Government Accountability Office

GAO

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

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MEDICAID

Extent of Dental Disease in Children Has Not Decreased

Statement of Alicia Puente Cackley
Acting Director, Health Care



GAO-08-1176T

September 23, 2008



Highlights of GAO-08-1176T, a testimony before the Subcommittee on Domestic Policy, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

In recent years, concerns have been raised about the adequacy of dental care for low-income children. Attention to this subject became more acute due to the widely publicized case of Deamonte Driver, a 12-year-old boy who died as a result of an untreated infected tooth that led to a fatal brain infection. Deamonte had health coverage through Medicaid, a joint federal and state program that provides health care coverage, including dental care, for millions of low-income children. Deamonte had extensive dental disease and his family was unable to find a dentist to treat him.

GAO was asked to examine the extent to which children in Medicaid experience dental disease, the extent to which they receive dental care, and how these conditions have changed over time. To examine these indicators of oral health, GAO analyzed data, by insurance status, from two nationally representative surveys of the Department of Health and Human Services (HHS): the National Health and Nutrition Examination Survey (NHANES) and the Medical Expenditure Panel Survey (MEPS). This statement summarizes the resulting report being released today, *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay* (GAO-08-1121). In commenting on a draft of the report, HHS acknowledged the challenge of providing dental services to children in Medicaid, and cited the agency's related activities.

To view the full product, including the scope and methodology, click on GAO-08-1176T. For more information, contact Alicia Puente Cackley at (202) 512-7114 or cackleya@gao.gov.

MEDICAID

Extent of Dental Disease in Children Has Not Decreased

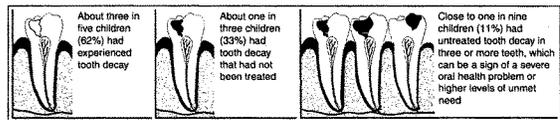
What GAO Found

Dental disease remains a significant problem for children aged 2 through 18 in Medicaid. Nationally representative data from the 1999 through 2004 NHANES surveys—which collected information about oral health through direct examinations—indicate that about one in three children in Medicaid had untreated tooth decay, and one in nine had untreated decay in three or more teeth (see figure). Projected to 2005 enrollment levels, GAO estimates that 6.5 million children aged 2 through 18 in Medicaid had untreated tooth decay. Children in Medicaid remain at higher risk of dental disease compared to children with private health insurance; children in Medicaid were almost twice as likely to have untreated tooth decay.

Receipt of dental care also remains a concern for children aged 2 through 18 in Medicaid. Nationally representative data from the 2004 through 2005 MEPS survey—which asks participants about the receipt of dental care for household members—indicate that only one in three children in Medicaid ages 2 through 18 had received dental care in the year prior to the survey. Similarly, about one in eight children reportedly never sees a dentist. More than half of children with private health insurance, by contrast, had received dental care in the prior year. Children in Medicaid also fared poorly when compared to national benchmarks, as the percentage of children in Medicaid who received any dental care—37 percent—was far below the Healthy People 2010 target of having 66 percent of low-income children under age 19 receive a preventive dental service.

Survey data on Medicaid children's receipt of dental care showed some improvement; for example, use of sealants went up significantly between the 1988 through 1994 and 1999 through 2004 time periods. Rates of dental disease, however, did not decrease, although the data suggest the trends vary somewhat among different age groups. Younger children in Medicaid—those aged 2 through 5—had statistically significant higher rates of dental disease in the more recent time period as compared to earlier surveys. By contrast, data for Medicaid adolescents aged 16 through 18 show declining rates of tooth decay, although the change was not statistically significant.

Proportion of Children in Medicaid Aged 2 through 18 with Tooth Decay, Untreated Tooth Decay, and Untreated Tooth Decay in Three or More Teeth, 1999-2004



Source: GAO analysis of 1999 through 2004 NHANES survey data.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you further examine concerns related to the adequacy of dental services for children in Medicaid. My testimony will provide a summary of our report for the subcommittee, which you are releasing today, entitled *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*.¹ This report provides information following the May 2007 and February 2008 subcommittee hearings investigating concerns related to the provision of dental services to children in Medicaid. These hearings investigated the circumstances of Deamonte Driver, a 12-year-old boy with Medicaid coverage who did not receive timely and needed dental care and who died as a result of an untreated infected tooth that led to a fatal brain infection. As you know, Medicaid—the joint federal and state program that provides health care coverage for millions of low-income individuals—provides comprehensive dental coverage for enrolled children.² Concerns raised at the hearings about low-income children's oral health, including the extent that children in Medicaid experience dental disease and receive dental care, are not new. GAO reviews conducted in the late 1990s highlighted the problem of chronic dental disease and the factors that contribute to low use of dental care by low-income populations, including children in Medicaid.³

Our new work examined two aspects of children's oral health: the extent to which children in Medicaid experience dental disease and the extent to which they receive dental care. We also assessed how these conditions have changed over time. Our work provides information from national health surveys on key indicators of the oral health status of children in Medicaid, specifically, the rate of dental disease and their receipt of dental care, and changes in these indicators over time.

¹GAO, *MEDICAID: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*, GAO-08-1121 (Washington, D.C.: Sept. 23, 2008).

²Low-income children eligible under a state Medicaid plan generally are entitled to screening, diagnostic, preventive, and treatment services—including dental services—under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The Centers for Medicare & Medicaid Services (CMS) oversees state Medicaid programs at the federal level.

³A list of related GAO products can be found at the end of this statement.

In carrying out this work, we analyzed data from a survey conducted by the Department of Health and Human Services (HHS)—the National Health and Nutrition Examination Survey (NHANES). NHANES, which is administered by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, obtains nationally representative information on the health and nutritional status of the U.S. population through direct physical examinations, including dental examinations, and interviews. The dental examinations include a dentist's assessment of tooth decay and the presence of dental sealants, and the interviews include questions on various health and demographic characteristics, including information on insurance status. To assess how the rate of dental disease experienced by children in Medicaid has changed over time, we compared NHANES data from 1999 through 2004 with NHANES data from 1988 through 1994. We analyzed results from three different groups based on their health insurance status: children with Medicaid,⁴ children with private health insurance, and uninsured children. The group of children with private insurance included both children with dental coverage and children without dental coverage,⁵ while the group of uninsured was children who had neither health insurance nor dental insurance.

To assess how receipt of dental care has changed over time, we also analyzed data from another HHS survey, the Medical Expenditure Panel Survey (MEPS). MEPS is administered by HHS's Agency for Healthcare Research and Quality (AHRQ). MEPS obtains nationally representative information on Americans' health insurance coverage and use of health care, including information on receipt of dental care such as how often participants see a dentist and whether they have experienced problems accessing needed dental care. Our MEPS analysis was based on surveys conducted in 2004 and 2005 (the most recent data available). To assess changes in receipt of dental care over time, we compared the data from 2004 and 2005 with MEPS data from 1996 and 1997. We analyzed the MEPS data using the same three insurance groups as we used for the NHANES

⁴Our figures for Medicaid include children enrolled in the State Children's Health Insurance Program (SCHIP), because NHANES contains a single category that combines Medicaid and SCHIP beneficiaries. SCHIP provides health care coverage to children in low-income families who are not eligible for traditional Medicaid programs.

⁵We analyzed the data for privately insured children with and without dental coverage separately, and found that the indicators of oral health and dental utilization for both groups were similar. Consequently, we present the data for children with private insurance as one group.

data. To estimate the number of children in each Medicaid category with a given condition, we applied certain proportions from NHANES or MEPS data to an estimate of the 2005 average monthly Medicaid enrollment of children aged 2 through 18 (20.1 million children).⁶ Finally, we obtained information on oral health and the Medicaid population from CDC and from dental associations and experts including the Children's Health Dental Project and the Medicaid/SCHIP Dental Association. The work for our report was conducted in accordance with generally accepted government auditing standards from December 2007 through September 2008. A detailed explanation of our methodology is included in the report.

In summary, dental disease and inadequate receipt of dental care remain significant problems for children in Medicaid. Nationally representative survey data from 1999 through 2004 indicate that about one in three children aged 2 through 18 in Medicaid had untreated tooth decay, and one in nine had untreated decay in three or more teeth. Projecting the survey results to the 2005 average monthly Medicaid enrollment of 20.1 million children, we estimate that 6.5 million children aged 2 through 18 in Medicaid had untreated tooth decay. Children in Medicaid remain at higher risk of dental disease compared to children who have private health insurance; children in Medicaid were almost twice as likely to have untreated tooth decay.

Survey data from 2004 and 2005 showed that only about one in three children in Medicaid aged 2 through 18 had received dental care in the prior year; about one in eight children reportedly never sees the dentist. More than half of children with private health insurance, by contrast, had received dental care in the prior year. Children in Medicaid also fared poorly when compared to national benchmarks, as the percentage of children in Medicaid aged 2 through 18 who received any dental care—37 percent—was far below HHS's Healthy People 2010 target of having 66 percent of low-income children under age 19 receive a preventive dental service in the prior year.

⁶To assess the reliability of NHANES and MEPS data, we spoke with knowledgeable agency officials, reviewed related documentation, and compared our results to published data. We determined these data to be reliable for the purposes of our work.

Survey data on Medicaid children's receipt of dental care showed some improvement over time. For example, comparison of survey data from 1988 through 1994 to more recent data from 1999 through 2004 showed that the percentage of children aged 6 through 18 in Medicaid with at least one dental sealant increased nearly threefold, from 10 percent in 1988 through 1994 to 28 percent in 1999 through 2004. However, over the same time periods, dental disease in the overall Medicaid population aged 2 through 18 did not decrease, although the data suggest the trends vary somewhat among different age groups. Younger children—those aged 2 through 5—had statistically significant higher rates of dental disease in the more recent time period examined as compared to earlier surveys. By contrast, data for adolescents—children in Medicaid aged 16 through 18—show declining rates of tooth decay, although the change was not statistically significant.

In commenting on a draft of our report, HHS provided comments from three component agencies: CMS, CDC, and AHRQ. CMS acknowledged the challenge of providing dental services to children in Medicaid, as well as all children nationwide, and cited a number of activities undertaken by CMS in coordination with states. CDC commented that trends in dental caries (tooth decay) vary by age group and for primary versus permanent teeth. We revised our report to further clarify the trends by age group and added information on CDC's findings in the general population. AHRQ commented that its own work on dental use, expenses, dental coverage, and changes had not been cited and sought additional clarification on the methodology used to analyze the data. We revised our report to cite AHRQ's findings on dental services for children and to further describe our methodology. A full copy of HHS's written comments can be found in our report.

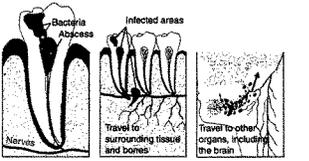
Background

In 2000, a report of the Surgeon General noted that tooth decay is the most common chronic childhood disease.⁷ Left untreated, the pain and infections caused by tooth decay may lead to problems in eating, speaking, and learning. Tooth decay is almost completely preventable, and the pain, dysfunction, or on extremely rare occasion, death, resulting from dental disease can be avoided (see fig. 1). Preventive dental care can make a

⁷U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, *Oral Health in America: A Report of the Surgeon General* (Rockville, Md., 2000).

significant difference in health outcomes and has been shown to be cost-effective. For example, a 2004 study found that average dental-related costs for low-income preschool children who had their first preventive dental visit by age 1 were less than one-half (\$262 compared to \$546) of average costs for children who received their first preventive visit at age 4 through 5.⁸

Figure 1: Tooth Decay and Its Possible Adverse Outcomes If Untreated

	<p>What is tooth decay?</p> <p>The American Academy of Pediatric Dentistry describes dental caries (commonly known as cavities or tooth decay) as a process where bacteria in the mouth form acids which demineralize tooth enamel. Tooth decay can be prevented by good oral health practices, such as brushing with fluoride toothpaste regularly, but if not treated, could result in pain, infection, and tooth loss.</p>
	<p>How can tooth decay lead to death?</p> <p>Untreated tooth decay can penetrate the tooth surface, allowing bacteria to infect the interior of the tooth, causing an abscess. From there, if the infection is not dealt with by antibiotics or other treatment, it can travel to surrounding tissue or other organs, including the brain, and on extremely rare occasions, cause death.</p>

Source: GAO and the American Academy of Pediatric Dentistry.

The American Academy of Pediatric Dentistry (AAPD) recommends that each child see a dentist when his or her first tooth erupts and no later than the child's first birthday, with subsequent visits occurring at 6-month intervals or more frequently if recommended by a dentist. The early initial visit can establish a "dental home" for the child, defined by AAPD as the ongoing relationship with a dental provider who can ensure comprehensive and continuously accessible care. Comprehensive dental visits can include both clinical assessments, such as for tooth decay and

⁸Matthew F. Savage, Jessica Y. Lee, Jonathan B. Kotch, and William F. Vann Jr., "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs," *Pediatrics*, 114 (2004). The study examined the effects of preventive care on subsequent utilization and costs of dental services among preschool-aged children in North Carolina continuously enrolled in Medicaid between 1992 and 1997.

sealants,⁹ and appropriate discussion and counseling for oral hygiene, injury prevention, and speech and language development, among other topics. Because resistance to tooth decay is determined in part by genetics, eating patterns, and oral hygiene, early prevention is important. Delaying the onset of tooth decay may also reduce long-term risk for more serious decay by delaying the exposure to caries risk factors to a time when the child can better control his or her health behaviors.

Recognizing the importance of good oral health, HHS in 1990 and again in 2000 established oral health goals as part of its Healthy People 2000 and 2010 initiatives. These include objectives related to oral health in children, for example, reducing the proportion of children with untreated tooth decay. One objective of Healthy People 2010 relates to the Medicaid population: to increase the proportion of low-income children and adolescents under the age of 19 who receive any preventive dental service in the past year, from 25 percent in 1996 to 66 percent in 2010.¹⁰

Medicaid, a joint federal and state program that provides health care coverage for low-income individuals and families; pregnant women; and aged, blind, and disabled people, provided health coverage for an estimated 20.1 million children aged 2 through 18 in federal fiscal year 2005.¹¹ The states operate their Medicaid programs within broad federal requirements and may contract with managed-care organizations to provide Medicaid benefits or use other forms of managed care, when approved by CMS. CMS estimates that as of June 30, 2006, about 65 percent of Medicaid beneficiaries received benefits through some form of managed care.¹² State Medicaid programs must cover some services for

⁹According to AAPD, dental sealants, a plastic material put on the chewing surfaces of back teeth, have been shown to prevent decay on tooth surfaces where food and bacteria can build up. AAPD recommends sealants for 6-year and 12-year molars as soon as possible after eruption.

¹⁰The Healthy People 2010 goal was increased from 57 percent when it was first established in 2000 to 66 percent during a mid-course review in the mid-2000s. The goal defines preventive dental care to include examination, x-ray, fluoride treatment, cleaning, or sealant application. See U.S. Department of Health and Human Services, Public Health Service, *Progress Review: Oral Health* (Feb. 7, 2008).

¹¹Estimate based on CMS statistics for children ages 1 through 18 in Medicaid, less the estimated number of children aged 1 in that group (the latter of which was estimated using Census data).

¹²CMS's statistics include the Medicaid population enrolled in capitated plans (typically defined as plans that contract with states to receive a prepaid per enrollee payment for coverage of Medicaid services) and primary-care-case management models.

certain populations under federal law. For instance, under Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit, states must provide dental screening, diagnostic, preventive, and related treatment services for all eligible Medicaid beneficiaries under age 21.¹³

Dental Disease and Inadequate Receipt of Dental Care Remain Significant Problems for Children in Medicaid

Children in Medicaid aged 2 through 18 often experience dental disease and often do not receive needed dental care, and although receipt of dental care has improved somewhat in recent years, the extent of dental disease for most age groups has not. Information from NHANES surveys from 1999 through 2004 showed that about one in three children ages 2 through 18 in Medicaid had untreated tooth decay, and one in nine had untreated decay in three or more teeth. Compared to children with private health insurance, children in Medicaid were substantially more likely to have untreated tooth decay and to be in urgent need of dental care. MEPS surveys conducted in 2004 and 2005 found that almost two in three children in Medicaid aged 2 through 18 had not received dental care in the previous year and that one in eight never sees a dentist. Children in Medicaid were less likely to have received dental care than privately insured children, although they were more likely to have received care than children without health insurance. Children in Medicaid also fared poorly when compared to national benchmarks, as the percentage of children in Medicaid ages 2 through 18 who received any dental care—37 percent—was far below the Healthy People 2010 target of having 66 percent of low-income children under age 19 receive a preventive dental service.¹⁴ MEPS data on Medicaid children who had received dental care—from 1996 through 1997 compared to 2004 through 2005—showed some improvement for children ages 2 through 18 in Medicaid. Comparisons of recent NHANES data to data from the late 1980s and 1990s suggest that the extent that children ages 2 through 18 in Medicaid experience dental disease has not decreased for most age groups.

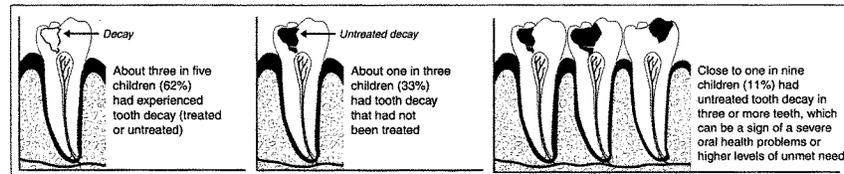
¹³These Medicaid dental services must be provided at intervals which meet reasonable standards of dental practice or as medically necessary and must include relief of pain and infections, restoration of teeth, and maintenance of dental health.

¹⁴MEPS measures receipt of any dental care, whereas the 2010 Healthy People target is for receipt of a preventive dental service. This comparison may underestimate the actual gap.

National Survey Data from 1999 through 2004 Show That One in Three Children in Medicaid Had Untreated Tooth Decay

Dental disease is a common problem for children aged 2 through 18 enrolled in Medicaid, according to national survey data (see fig. 2). NHANES oral examinations conducted from 1999 through 2004 show that about three in five children (62 percent) in Medicaid had experienced tooth decay,¹⁵ and about one in three (33 percent) were found to have untreated tooth decay.¹⁶ Close to one in nine—about 11 percent—had untreated decay in three or more teeth, which is a sign of unmet need for dental care and, according to some oral health experts, can suggest a severe oral health problem. Projecting these proportions to 2005 enrollment levels, we estimate that 6.5 million children in Medicaid had untreated tooth decay, with 2.2 million children having untreated tooth decay involving three or more teeth.¹⁷

Figure 2: Proportion of Children in Medicaid Aged 2 through 18 with Tooth Decay, Untreated Tooth Decay, and Untreated Tooth Decay in Three or More Teeth, 1999-2004



Source: GAO analysis of 1999 through 2004 NHANES survey data.

Note: The NHANES survey data for Medicaid also include data for children in SCHIP, which we estimate to be about 15 percent of the total.

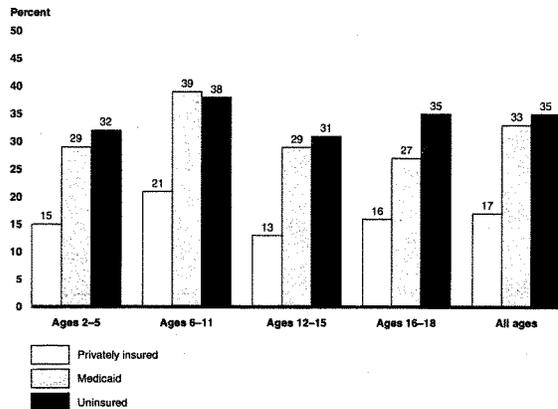
¹⁵We considered children as having experienced tooth decay if he or she had a tooth with untreated decay, had a tooth that had been treated for decay (meaning had a filling), or had lost a tooth due to decay.

¹⁶The extent of dental disease may be even more severe than these statistics suggest. Oral health experts told us that the extent of untreated tooth decay identified in NHANES is likely an underestimate because NHANES examiners consider a tooth as decayed only if the decay is "visibly significant."

¹⁷These estimates are based on 95 percent confidence intervals—that is, there is a 95 percent probability that the actual number falls within this range. For children with untreated tooth decay, the lower and upper limits are 5.9 million and 7.1 million, respectively. For children with untreated tooth decay in three or more teeth, the lower and upper limits are 1.9 million and 2.6 million, respectively.

Compared with children with private health insurance, children in Medicaid were at much higher risk of tooth decay and experienced problems at rates more similar to those without any insurance. As shown in figure 3, the proportion of children in Medicaid with untreated tooth decay (33 percent) was nearly double the rate for children who had private insurance (17 percent) and was similar to the rate for uninsured children (35 percent). These children were also more than twice as likely to have untreated tooth decay in three or more teeth than their privately insured counterparts (11 percent for Medicaid children compared to 5 percent for children with private health insurance). These disparities were consistent across all age groups we examined.

Figure 3: Percentage of Children Aged 2 through 18 with Untreated Tooth Decay, by Age and Insurance Status, 1999-2004



Source: GAO analysis of 1999 through 2004 NHANES survey data.

Note: The NHANES survey data for Medicaid also include data for children in SCHIP, which we estimate to be about 15 percent of the total.

According to NHANES data, more than 5 percent of children in Medicaid aged 2 through 18 had urgent dental conditions, that is, conditions in need of care within 2 weeks for the relief of symptoms and stabilization of the condition. Such conditions include tooth fractures, oral lesions, chronic pain, and other conditions that are unlikely to resolve without professional intervention. On the basis of these data, we estimate that in 2005, 1.1 million children aged 2 through 18 in Medicaid had conditions that warranted seeing a dentist within 2 weeks.¹⁸ Compared to children who had private insurance, children in Medicaid were more than four times as likely to be in urgent need of dental care.

The NHANES data suggest that the rates of untreated tooth decay for some Medicaid beneficiaries could be about three times more than national health benchmarks. For example, the NHANES data showed that 29 percent of children in Medicaid aged 2 through 5 had untreated decay, which compares unfavorably with the Healthy People 2010 target for untreated tooth decay of 9 percent of children aged 2 through 4.¹⁹

¹⁸This estimate is based on a 95 percent confidence interval—that is, there is a 95 percent probability that the actual number falls within a specific range. For children with an urgent need to see a dentist, the lower and upper limits of the range are 700,000 and 1.5 million, respectively.

¹⁹The age groups we used for our analysis of NHANES differ slightly from the age groups measured for purposes of Healthy People 2010. According to HHS, prevalence of untreated tooth decay among 2- through 4-year-olds in the general population increased from 16 percent during the 1988 through 1994 time period, to 19 percent for the 1999 through 2004 period (this increase was not statistically significant). For this objective, the trends may be moving in the opposite direction of the target. HHS has also reported that among young children aged 2 to 4 years, the prevalence of tooth decay in primary teeth increased from 13 percent in 1988 through 1994 to 24 percent in 1999 through 2004. By comparison with older children, tooth decay in preschool children in the general population increased significantly. According to HHS, this trend could portend a future increase in tooth decay in older children, as influenced by changes in diet or food consumption patterns. The target for this goal is 11 percent.

National Survey Data from 2004 through 2005 Showed That Nearly Two in Three Children in Medicaid Did Not Receive Dental Care in the Previous Year

Most children in Medicaid do not visit the dentist regularly, according to 2004 and 2005 nationally representative MEPS data (see fig. 4). According to these data, nearly two in three children in Medicaid aged 2 through 18 had not received any dental care in the previous year.²⁰ Projecting these proportions to 2005 enrollment levels, we estimate that 12.6 million children in Medicaid have not seen a dentist in the previous year.²¹ In reporting on trends in dental visits of the general population, AHRQ reported in 2007 that about 31 percent of poor children (family income less than or equal to the federal poverty level) and 34 percent of low-income children (family income above 100 percent but less than or equal to 200 percent of the federal poverty level) had a dental visit during the year.²² Survey data also showed that about one in eight children (13 percent) in Medicaid reportedly never see a dentist.²³

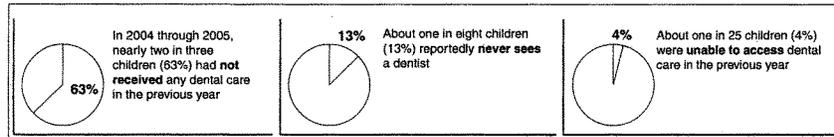
²⁰MEPS asks an adult if the children in the household had received any dental care in the previous year. If they respond affirmatively, then surveyors ask about the type of provider they visited: a dentist, a hygienist, oral surgeon, orthodontist, endodontist, periodontist, or dental technician.

²¹This estimate is based on a 95 percent confidence interval—that is, there is a 95 percent probability that the actual number falls within a specific range. For children without a dental visit in the previous year, the lower and upper limits of this range are 12.1 million and 13.0 million, respectively.

²²U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, "Dental Use, Expenses, Private Dental Coverage, and Changes, 1996 and 2004," *MEPS Chartbook*, no. 17 (2007), http://www.meps.ahrq.gov/mepsweb/data_files/publications/cb17/cb17.pdf (downloaded Sept. 16, 2008).

²³As part of the MEPS survey, participants are asked: "On average, how often does [person] receive a dental check-up?" One of the responses to this question is that the individual in question "never goes to a dentist." The percentage of children who "never go to the dentist" varied by age group. The youngest group, ages 2 through 5, was the group most likely to never see a dentist, with 30 percent of children falling in that category. However, even some of the older children never see a dentist. We found that about 10 percent of children aged 16 through 18 in Medicaid were in this category.

Figure 4: Proportion of Children in Medicaid Nationwide Not Receiving Dental Care or Unable to Access Dental Care, 2004–2005



Source: GAO analysis of 2004 through 2005 MEPS survey data.

Note: The MEPS survey data for Medicaid also include data for children in SCHIP, which we estimate to be about 16 percent of the total.

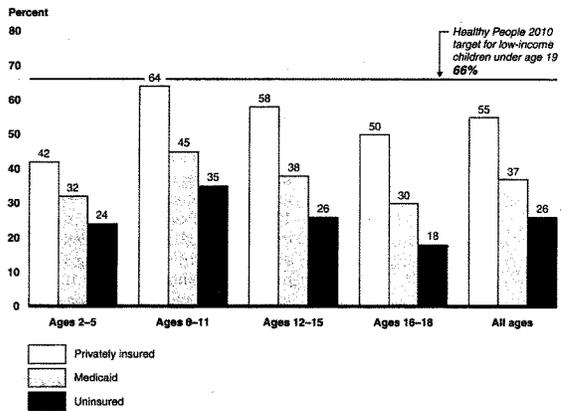
MEPS survey data also show that many children in Medicaid were unable to access needed dental care. Survey participants reported that about 4 percent of children aged 2 through 18 in Medicaid were unable to get needed dental care in the previous year. Projecting this percentage to estimated 2005 enrollment levels, we estimate that 724,000 children aged 2 through 18 in Medicaid could not obtain needed care.²⁴ Regardless of insurance status, most participants who said a child could not get needed dental care said they were unable to afford such care.²⁵ However, 15 percent of children in Medicaid who had difficulty accessing needed dental care reportedly were unable to get care because the provider refused to accept their insurance plan, compared to only 2 percent of privately insured children.

²⁴This estimate is based on a 95 percent confidence interval—that is, there is a 95 percent probability that the actual number falls within a specific range. For children who could not obtain needed dental care, the lower and upper limits of this range are 543,000 and 894,000, respectively.

²⁵MEPS asked participants for the reason they were unable to get needed care. Possible responses included (1) could not afford care, (2) insurance company would not approve/cover/pay, (3) doctor refused insurance plan, (4) problems getting to doctor's office, (5) could not get time off work, (6) didn't know where to get care, (7) was refused services, (8) could not get child care, (9) did not have time, and (10) other. MEPS is a nationally representative survey that also includes privately insured and uninsured individuals; it does not illuminate why beneficiaries with health coverage such as Medicaid (which has no cost sharing for certain beneficiaries) would report that they could not afford care, or the reasons for providers refusing to accept insurance plans.

Children enrolled in Medicaid were less likely to have received dental care than privately insured children, but they were more likely to have received dental care than children without health insurance. (See fig. 5.) Survey data from 2004 through 2005 showed that about 37 percent of children in Medicaid aged 2 through 18 had visited the dentist in the previous year, compared with about 55 percent of children with private health insurance, and 26 percent of children without insurance. The percentage of children in Medicaid who received any dental care—37 percent—was far below the Healthy People 2010 target of having 66 percent of low-income children under age 19 receive a preventive dental service.

Figure 5: Percentage of Children in Medicaid Nationwide Who Received Dental Care in the Previous Year, by Age and Insurance Status, 2004-2005



Source: GAO analysis of 2004 through 2005 MEPS survey data.

Note: The MEPS survey data for Medicaid also include data for children in SCHIP, which we estimate to be about 16 percent of the total.

The NHANES data from 1999 through 2004 also provide some information related to the receipt of dental care. The presence of dental sealants, a form of preventive care, is considered to be an indicator that a person has received dental care. About 28 percent of children in Medicaid had at least one dental sealant, according to 1999 through 2004 NHANES data. In contrast, about 40 percent of children with private insurance had a sealant. However, children in Medicaid were more likely to have sealants than children without health insurance (about 20 percent).

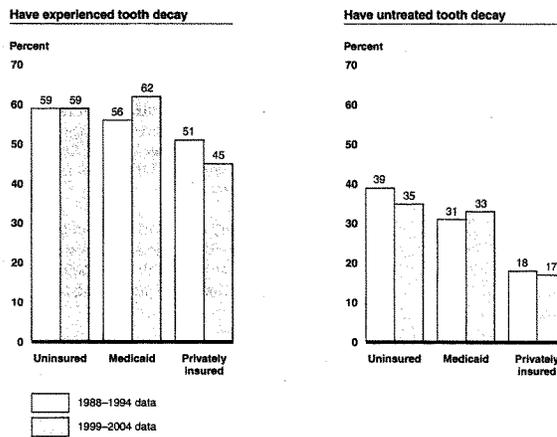
Comparison of Past and Recent Survey Data Suggests That the Rate of Dental Disease in Children in Medicaid Is Not Decreasing, although the Receipt of Dental Care Has Improved Somewhat in More Recent Years

While comparisons of past and more recent survey data suggest that a larger proportion of children in Medicaid had received dental care in recent surveys, the extent that children in Medicaid experience dental disease has not decreased. A comparison of NHANES results from 1988 through 1994 with results from 1999 through 2004 showed that the rates of untreated tooth decay were largely unchanged for children in Medicaid aged 2 through 18: 31 percent of children had untreated tooth decay in 1988 through 1994, compared with 33 percent in 1999 through 2004 (see fig. 6). The proportion of children in Medicaid who experienced tooth decay increased from 56 percent in the earlier period to 62 percent in more recent years. This increase appears to be driven by younger children, as the 2 through 5 age group had substantially higher rates of dental disease in the more recent time period, 1999 through 2004.²⁶ This preschool age group experienced a 32 percent rate of tooth decay in the 1988 through 1994 time period, compared to almost 40 percent experiencing tooth decay in 1999 through 2004 (a statistically significant change). Data for adolescents, by contrast, suggest declining rates of tooth decay. Almost 82 percent of adolescents aged 16 through 18 in Medicaid had experienced tooth decay in the earlier time period, compared to 75 percent in the latter time period (although this change was not statistically significant). These trends were similar for rates of untreated tooth decay, with the data suggesting rates going up for young children, and declining or remaining the same for older groups that are more likely to have permanent teeth. According to CDC, these trends are similar for the general population of children, for which tooth decay in permanent teeth has generally declined

²⁶We found that the rates of untreated tooth decay for children with Medicaid did not decrease from the period 1988 through 1994 to the period 1999 through 2004. Similarly, CDC found that the rates of untreated primary tooth decay in children aged 2 through 11 had not decreased between 1988 through 1994 and 1999 through 2004. However, CDC has found that rates of untreated tooth decay in permanent teeth for low-income children have declined since the early 1970s.

and untreated tooth decay has remained unchanged. CDC also found that tooth decay in preschool aged children in the general population had increased in primary teeth.

Figure 6: Surveyed Measures of Tooth Decay Rates, by insurance Status, 1988-1994 and 1999-2004



Source: GAO analysis of 1988 through 1994 and 1999 through 2004 NHANES survey data.

Notes: For the privately insured and for those with Medicaid, changes between the two time periods in the percentage of children aged 2 through 18 who experienced tooth decay were statistically significant at the 95 percent level. For this measure, changes in the percentage of children aged 2 through 18 who were uninsured were not statistically significant. For untreated tooth decay, none of the changes between the two time periods were found to be statistically significant at the 95 percent level. The 1999 through 2004 NHANES survey data for Medicaid also include data for children in SCHIP, which we estimate to be about 15 percent of the total.

At the same time, indicators of receipt of dental care, including the proportion of children who had received dental care in the past year and use of sealants, have shown some improvement. Two indicators of receipt of dental care showed improvement from earlier surveys:

- The percentage of children in Medicaid aged 2 through 18 who received dental care in the previous year increased from 31 percent in 1996 through

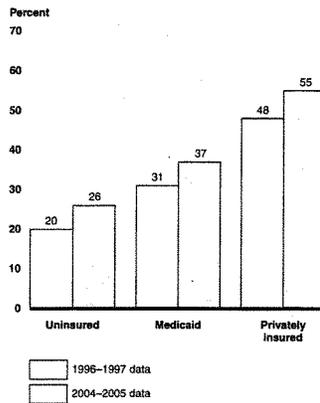
1997 to 37 percent in 2004 through 2005, according to MEPS data (see fig. 7). This change was statistically significant. Similarly, AHRQ reported that the percent of children with a dental visit increased between 1996 and 2004 for both poor children (28 percent to 31 percent) and low-income children (27 percent to 34 percent).

- The percentage of children aged 6 through 18 in Medicaid with at least one dental sealant increased nearly threefold, from 10 percent in 1988 through 1994 to 28 percent in 1999 through 2004, according to NHANES data, and these changes were statistically significant. The increase in receipt of sealants may be due in part to the increased use of dental sealants in recent years, as the percentage of uninsured and insured children with dental sealants doubled over the same time period.²⁷ Adolescents aged 16 through 18 in Medicaid had the greatest increase in receipt of sealants relative to other age groups. The percentage of adolescents with dental sealants was about 6 percent in the earlier time period, and 33 percent more recently.

The percentage of children in Medicaid who reportedly never see a dentist remained about the same between the two time periods, with about 14 percent in 1996 through 1997 who never saw a dentist, and 13 percent in 2004 through 2005, according to MEPS data.

²⁷According to HHS officials, many state health departments have long-term programs that have delivered sealants to a sizable number of low-income children over the past decade. See for example, CDC, "Impact of Targeted, School-Based Dental Sealant Programs in Reducing Racial and Economic Disparities in Sealant Prevalence Among School Children, Ohio, 1998-1999," *Morbidity and Mortality Weekly Report*, 50 no. 34 (2001), 736-8.

Figure 7: Surveyed Measures of Children Who Visited a Dentist in the Previous Year, by Insurance Status, 1996-1997 and 2004-2005



Source: GAO analysis of 1996 through 1997 and 2004 through 2005 MEPS survey data.

Notes: For each group, changes between the two time periods in the percentage of children aged 2 through 18 who had received dental care in the previous year were statistically significant at the 95 percent level. The 2004 through 2005 MEPS survey data for Medicaid also include data for children in SCHIP, which we estimate to be about 16 percent of the total.

More information on our analysis of NHANES and MEPS for changes in dental disease and receipt of dental care for children in Medicaid over time, including comments we received from HHS on a draft of the report and our response, more detailed data tables, and confidence intervals can be found in the report released today.

Concluding Observations

The information provided by nationally representative surveys regarding the oral health of our nation's low-income children in Medicaid raises serious concerns. Measures of access to dental care for this population, such as children's dental visits, have improved somewhat in recent surveys, but remain far below national health goals. Of even greater concern are data that show that dental disease is prevalent among children in Medicaid, and is not decreasing. Millions of children in Medicaid are estimated to have dental disease in need of treatment; in many cases this

need is urgent. Given this unacceptable condition, it is important that those involved in providing dental care to children in Medicaid—the federal government, states, providers, and others—address the need to improve the oral health condition of these children and to achieve national oral health goals. As you know, we have ongoing work for the subcommittee examining state and federal efforts to ensure that children in Medicaid receive needed dental services. We expect to report to the subcommittee on our findings and any recommendations in spring 2009.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions that you or other members of the Subcommittee may have.

GAO Contacts and Acknowledgments

For information regarding this testimony, please contact Alicia Puente Cackley at (202) 512-7114 or cackleya@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Katherine Iritani, Assistant Director; Sarah Burton; and Terry Saiki made key contributions to this statement.

Related GAO Products

Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay. GAO-08-1121. Washington, D.C.: September 23, 2008.

Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services. GAO-07-826T. Washington, D.C.: May 2, 2007.

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

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Mr. KUCINICH. Thank you very much, Ms. Cackley. I would like to start with you.

Why is the oral health condition in children with Medicaid not improving if receipt of dental care has improved?

Ms. CACKLEY. That is a very good question. It seems counter-intuitive. I think part of the explanation in part can come from looking at the age differences in the children. When we look at tooth decay in younger children, we see a much larger increase, and that seems to be driving the overall trend that we see, whereas older children, who are the ones most likely to receive dental sealants, have no change, no increase in tooth decay over time.

Mr. KUCINICH. Well, in your testimony you say that children from birth to three are not among the population of children who are receiving greater treatment in the past 26 years. Please elaborate on this finding. Also, what policies would you recommend to Federal and State agencies to address lack of care for the youngest sector of children in our Nation.

Ms. CACKLEY. The youngest children, in part, what we found was that younger children did not receive dental sealants, and partly that is it is not recommended for very young children. Dental sealants are for permanent teeth and not for the children who still have their primary teeth.

We don't have recommendations of specific policies at this point, partly because we are still doing the work on looking at what State Medicaid programs and their dental programs do have in place, and I think our ongoing work will be able to give you more recommendations at a later time.

Mr. KUCINICH. Can you elaborate on how the condition of dental disease in Medicaid children compared to children with private health insurance and children without any insurance?

Ms. CACKLEY. Absolutely. The children in Medicaid had much higher rates of tooth decay than children with private insurance, and over time we actually saw children with private insurance having lower rates of tooth decay, whereas children on Medicaid had higher rates, and uninsured children, basically their rates remained unchanged.

Mr. KUCINICH. So why do you think that is? Why do you think that children who have Medicaid have a higher rate of tooth decay? They have the coverage, right, but they are not getting the service? Is that it?

Ms. CACKLEY. That is correct. They definitely have coverage. There are a number of reasons why they are not getting services. In previous work that we have done, we looked at the participants in our surveys who responded also to why they did not have access to dental care, and in many cases they responded that there were either cost issues or access issues in terms of ability to find a dentist or ability to travel to the dentist, so there are a number of different responses that were given as to what the problem could be.

Mr. KUCINICH. So in your model for further research, you are going to take into account the distance between providers and people who are clients?

Ms. CACKLEY. Our ongoing work is looking more particularly at the State Medicaid programs and what they are doing, the initiatives that they are putting in place to improve access to care, which

could include improving transportation or just increasing the provider network so that people don't have to go so far in order to find a dentist who will treat them.

Mr. KUCINICH. If you see in some provider networks that a few dentists are seeing half the patients, how do you explain that?

Ms. CACKLEY. There are a number of reasons. In our previous work we learned that dentists gave for why they were not serving Medicaid children, and some of those included problems with payments, but also problems with missed appointments and administrative burden. Those are some of the reasons that we had learned about.

Mr. KUCINICH. Is there a point where GAO recommends that a health care provider should not list someone in their list of service providers if they are not willing to take Medicaid patients? But why should someone be listed as a service provider if they are not providing a service?

Ms. CACKLEY. I think that we will be looking very specifically at the Medicaid State programs and how they go about creating their network of providers and how they monitor, how CMS monitors the provision of services so that we will be able to tell you more about what the State regulations are on that. We don't have information at this time.

Mr. KUCINICH. Mr. Kuhn, the very nature of people who find themselves on Medicaid, many of them are on the lower end of the economic scale. Many of them have found themselves in situations that have led to a certain amount of social disorganization. Would you agree with that?

Mr. KUHN. I would agree with that statement. Yes.

Mr. KUCINICH. So if that is the case, what is the thinking then of CMS, in looking at factors of social disorganization with respect to the delivery of service? For example, if, as Deamonte Driver's mother was faced with, you try and basically this service isn't available, even though you are told, how are people supposed to know how you keep proceeding? There is a certain amount of skill in maneuvering the system, which is required to be able to get this service.

We want to provide dental services for children, and we are asking their parents to be able to be experts at maneuvering a system that most people who aren't burdened with the kind of problems that some of the poor may be burdened would have trouble negotiating.

Transportation. You have a provider who might be on the other side of a county. People may not have even traveled over there before. There may not be adequate public transportation. I mean, when you look at the lower rates of utilization, as evidenced by the higher rates of tooth decay, it seems to me that the old models of service providing that are based on a society that has been a little bit less mobile than this one, that has been perhaps a little bit more stable in terms of economics than this one, that those old models are not as reliable for the provision of service. And that, notwithstanding the progress that you have made and are ready to make, that it may be that, in order to continue to provide services to a growing population of Medicaid clients, that you may have to look at changing the way that you serve this program population.

Mr. Kuhn.

Mr. KUHN. Mr. Chairman, I would not only agree that we need to look at those; I think we need to challenge some of those old models. I think we are planning to challenge those in a number of different ways. I think the issues that you and the CBO have raised here in terms of the multi-factorial issues are all relevant that we have to look at when serving this population, and some of the challenges that we need to think about is, how good are these provider networks, whether they are MCOs or others, are reaching back out to the folks that are enrolled in the program and making sure that they are doing the appropriate followup, the proper education, the information that they need.

I think you will hear about it from some of the innovations that we are hearing from some of the States that are here today in terms of really trying to capture the service of non-dentists and others that are delivering care that can provide care, because if you look at the data that certainly I have seen and others, children on Medicaid and children overall tend to see a primary care physician or someone else much more frequently than they see a dentist. And in some cases and in some States because of licensure they are able to deliver at least some kind of services in those areas. Likewise with hygienists and others.

So I think we need to challenge some of the models that are out there and try to find better ways to do this.

I couldn't agree more.

Mr. KUCINICH. I want to recognize that CMS, since our last meeting in February and since your becoming Acting Director, and indicated by your testimony, under leadership CMS has done a much better job in addressing our policy recommendations. Significantly, it has resuscitated the oral health tag and enabled State dental agency leaders to collaborate with CMS and one another to tackle oral health disease. I want to thank you for that, and I hope that you will continue with your efforts in new and innovative ways.

I have a few questions that I wanted to ask of you in light of recent developments.

Before I do that, I want to recognize Mr. Higgins for the purposes of asking some questions.

Mr. Higgins, you may proceed.

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

Just for context, Ms. Cackley, do all States provide children's dental services under the Medicaid program?

Ms. CACKLEY. Yes, they do.

Mr. HIGGINS. All do? Obviously, some do it better than others.

Ms. CACKLEY. Yes.

Mr. HIGGINS. What are the models that are particularly effective that meet or exceed the benchmarks that were outlined in your study?

Ms. CACKLEY. The study that I just testified on was looking at the national data on receipt of dental services and prevalence of dental disease. It is the ongoing work where we will be able to talk about, across the State programs, what are some of the exemplary programs and where there are some places where we can make recommendations.

I don't have that information yet.

Mr. HIGGINS. Well, in assessing the problem, the period of study was between 2004 and 2005?

Ms. CACKLEY. Yes.

Mr. HIGGINS. Obviously, there are some that are more interesting and likely targets for further review based on the quality of these programs. I presume that these statistics are available on a State-by-State basis, as the Medicaid program is both funded by the Federal and the State governments.

Ms. CACKLEY. The data that our study is based on are data sets that are provided by HHS, the National Health and Nutrition Examination and the Medical Expenditure Panel, so they are aggregate data nationally representative.

Mr. HIGGINS. You are being too cautious with me.

Ms. CACKLEY. I am sorry?

Mr. HIGGINS. I am trying to understand this a little bit better.

I mean, it would seem to me, at the request of Congress, if you have identified in your report a public health issue that addresses children in this Nation, and that the Medicaid program, again, is funded by both the Federal and the State governments, and in some States like New York by local governments—25 percent, which comes from the property tax—it would seem to me that a good place to start is within those States that are doing well, and why is it that they are doing better than everybody else, and then looking at that State or those States collectively as a basis from which to perhaps recommend to Congress specific recommendations as you acknowledge that you are not doing here today.

Ms. CACKLEY. Right. You are absolutely right. What I am trying to say is that what we have done so far is to look at data that is not broken out State-by-State where the children live, so we can't give you that kind of information yet. The State-by-State kinds of information will come in the second phase.

Mr. HIGGINS. I would think that information would be very valuable.

Ms. CACKLEY. I am sure it will.

Mr. HIGGINS. Yes.

I have no further questions, Mr. Chairman. Thank you.

Mr. KUCINICH. Thank you, Mr. Higgins.

Mr. Kuhn, you mentioned that you have finalized 4 of the 17 early periodic screening and diagnostic treatment reviews, and that you have completed a draft of an additional seven of them. Can you tell us what challenges that all these States have in common?

Mr. KUHN. That is a good question. You know, in our written testimony on page 4 we list some of the initial observations that we are making as a result of all of our reviews of the States, and so when you look at it across the board what we are seeing here is that one of the fundamental things is clear information for beneficiaries, particularly those with different languages, particularly some that are of different cultures. Seems to be a barrier that we are seeing in all States in all the 17 areas.

Also, we see deficiencies in many of the States in terms of processes that would remind beneficiaries that recommended visits were due that are out there.

Updated provider listings, everybody seems to be falling down in terms of making sure those are current and adequate and they are appropriate that are in place there.

A process to track when recommended visits ought to be occurring seems to be a common theme we are seeing across the States.

These are some of the commonalities that we are seeing across the board.

Likewise, for providers we are seeing the same thing that I think this subcommittee has heard in the past—low provider payment rates, the issue of missed appointments that were mentioned earlier, and also sometimes with prior authorizations. Sometimes the dentists find those are burdensome.

So we are seeing those kind of common themes across the board.

Mr. KUCINICH. Why have people missed appointments? Do you ever go into deep detail about missed appointments? Are there any patterns?

Mr. KUHN. In one of the reviews I read in one of the States it was interesting, I think it was North Dakota, where the issue of missed appointments, the dental providers in that State, when they book an appointment with a Medicaid beneficiary, they double booked all those appointments because they said there was a high likelihood that the patient might not show up that day, and they didn't want an empty chair that is there. So we see some work-arounds the providers are doing. So as part of our reviews with these 17 States we have done detailed discussions with the providers to try to understand those kind of issues, what they are doing in order to ameliorate that.

I think the issue of double booking is an interesting one. It seems to me that if we were more effective at reminding people of visits and appointments and doing some other things we might be able to help work in that area, but these are some of the things that we are seeing.

Mr. KUCINICH. I want to go a little bit deeper into this discussion about CMS and, for that matter, any Federal service that is being provided, how service is being provided, other than dental.

If you are dealing with a population that is suffering from poverty and social disorganization, time, there is a different awareness of time. Now, I am speaking about this because this is basically how I grew up. Appointments don't mean the same thing to some people as they mean to others. Once you are working you are on a clock, there is a regimentation to life, you are out with the rest of society, you are moving with the crowd. Time, you are looking at a watch, means one thing. Some people, life doesn't work that way.

It is the awareness of that which I think is important to be able to deliver service, because in a way, when appointments are made, I think the followup, calling people, asking the providers to call people a day before an appointment, for example, reminding them there is an appointment, the day of an appointment reminding them there is an appointment, I mean, there is something about that I would like you to think about to take into account.

You know, this might sound a little bit like sociology, but let me tell you there is a practical application to doing this. There is also a practical application to outreach, to continual outreach to make

people aware of the provision of services to maximize the use of the Medicaid dollar, itself.

I just would like your response to that, and then I want to move on.

Mr. KUHN. I think those are good questions to ask, and in one regard I am very grateful that this particular hearing you have asked experts from the individual States who are actually on the ground grappling with those very issues as they implement these programs, so I will be interested to hear what they say.

But what we hear on our interviews is, in addition to the issue of missed appointments, one of the things that they said is absolutely right. People have work, and how does that integrate with their work schedule. They have babysitter issues that they have to deal with. They have transportation problems and issues that come up. So all of those are kind of multi-factorial things that I think we have to think about.

Are there different things that we could do at CMS to help support the States in that regard or are there additional innovations that States can bring forward to help these Medicaid beneficiaries navigate the system with those kind of issues and challenges that they face.

Mr. KUCINICH. I appreciate that response. You indicated that CMS targeted States reporting dental screening rates below 30 percent for focused dental reviews. However, a large number of States reported screening rates in the 30 to 40 percent range. What is CMS doing to improve access to Medicaid dental services in States beyond the initial targeted 15 States?

Mr. KUHN. Yes. What we have done in that regard, while we did focus on those 17 States, we have been in contact with each and every State to talk with them about the issues that are out there. We talked to them about trying to understand better what are the actions they are taking to followup with children, or at least the provider networks are following up with children to make sure that they are getting the services that they need and, as you so rightly said, that they are entitled to and that they deserve, to make sure that we are following up with each and every State to get the periodicity schedules. We have almost got those all done. We are still missing a few States. As we have shared with the subcommittee, we have shared with you the ones that are still missing and we hope to get those soon.

We want to hear more from the States what they are doing to recruit more dental providers, to make sure that they are there to service this population that is out there.

Also, we are exploring with them a lot these other States, as well, that are in that other range, what are the barriers that they are seeing, and are they doing anything recently in terms of dealing with provider rates, and are they taking action, are they considering action, and what more can we provide them to help them think those issues through.

Mr. KUCINICH. Thank you. As we will hear from the second panel, there is an inherent problem associated with risk-based contracts. Risk-based contracts are those written between the State and the managed care organization that allots a certain amount of funding for the managed care organization and tells it if it doesn't

use all of the funding for servicing children, it can keep the excess as profit.

On the other hand, if the managed care organization spends more than it has been allotted, it has to shoulder those costs.

This clearly creates an incentive for those MCOs to provide less service for children, and therefore make a profit. In fact, this was the case in Georgia, where MCOs faced, with loss of profits, shut down their provider networks, terminating existing contracts and limiting reimbursement for some of the most common dental procedures.

So tell me, No. 1, does CMS plan on drafting policy guidelines for States on how to draft contracts with MCOs in order to ensure the maximum access and utilization. And, second, what did you learn specifically about Georgia during the course of your early periodic screening and diagnostic treatment review, and could CMS have done differently to prevent the managed care organizations from limiting reimbursement and shutting down a dental provider network for the sake of their profits? Mr. Kuhn.

Mr. KUHN. On the issue of managed care organizations and risk contracts, 19 States currently use risk contracting for coverage for dental services; 15 of the States do it Statewide, 4 or more are kind of geographically limited in terms of the State. Quite frankly, I think risk contracting has a role in health care and in this area. It is a chance for us to try to find incentives to drive greater efficiency in the systems and try to find ways for better coordination of care, so I think there is a role for risk contracting that is out there.

Having said that, I think there are opportunities where we have seen where risk contracting has worked very good. I know I recently looked at a study out of Minnesota, as well as one out of New York, where they looked at their Medicaid programs under risk contracting and showed real good performance, particularly in the State of New York, for dental care. However, I recently looked at a study from the State of Kansas, where they showed better performance on fee-for-service side. So it is a mixed bag out there. I will be real candid with the subcommittee in that regard. It is a mixed bag.

So what we are trying to do in terms of our review is look at those States where they are getting terrific performance through their managed care contracts and what kind of policy options can we put forward in that regard.

I am not ready yet to commit to the subcommittee of what new guidance we might put out there for the States in terms of drafting contracts, because I don't think we are that far along in our evaluation. But one of the things I would like to do is that I am a big believer in greater transparency in health care, and I have been a very big advocate of what we have done at CMS in terms of our compare Web sites of getting data out on nursing homes and hospitals and others. I don't think there is enough information that is available to the public in terms of what is going on in dental care that is out there, and so I want us to be more transparent, and I think MCOs will be one area that I want to be transparent on as I go forward, so that I would say is one thing we are going to do in this area. The other is I think we need to finish our policy work.

In terms of what is going on in Georgia, we haven't finished that report yet, but I will tell you what we have seen thus far is that we are concerned with the overall adequacy of providers in their network in terms of their managed care organizations. We have already begun talking to the State about potential improvements that they can make, and we want to have those further conversations with the State as we go forward.

So basically that is where we are with that State. It looks like it is a pretty reasonable program they have put together, but they have hit some issues that we don't fully understand yet, and, as we finish our investigation, hopefully we will have more information we can share with you at that time.

Mr. KUCINICH. Well, as chairman of this subcommittee I just want to indicate to you that, with billions of Federal tax dollars involved in health care in this country, that I am very concerned about this issue of taxpayers' money going to provide services and then people not providing the services, having a structure where you actually incentivize not providing services so people can make a profit. Because it seems to me that, while you certainly want to promote the top utilization of services, you want to promote provider participation, people should be reimbursed at a rate that is sufficient enough to encourage the utilization instead of permitting a provider to capitalize on non-utilization.

This is something I would like you to just give some thought to, because whenever there is money that hasn't been used that can be converted into profit, it really opens a door for service providers to just find a way to game the system, so I would like you to think about that in your deliberations about the regulations that you are doing now.

Mr. KUHN. Those are helpful comments for us, and we will. I think in that regard what we want to make sure is that, as we continue to move forward on our efforts here, that we don't be so prescriptive that we say one size fits all, that this is the only way that dental services will be delivered in a State; that we want to make sure States have a menu of options that are workable, but at the same time we need real accountability in all these programs, and so I heard you loud and clear, Mr. Chairman.

Mr. KUCINICH. In our May 2007 investigation the subcommittee uncovered significant deficiencies in availability of dentists to treat Medicaid patients. Our most recent survey revealed that such deficiencies are not unique to Prince George's County, MD. What has CMS done to monitor and insure that all CMS Medicaid programs have adequate dental networks, especially those using a managed care model? And, similarly, what have you done to ensure that State Medicaid payment rates for dental services are adequate to enroll sufficient numbers of dentists to provide services comparable to the general population?

Mr. KUHN. As part of our 17-State review, we have made a number of recommendations to States already in terms of what we think they ought to be doing to improve the adequacy of their networks.

The other thing that we are looking at pretty hard is to make sure that we have some better reporting in terms of quality assessment reports that we get from States on an annual basis, those

States that have managed care organization contracts for dental providers, and are there ways that we can improve that reporting, make that information publicly available so we can create greater accountability out there as we go forward.

But one of the interesting things I noticed in the report that you all released on Friday, and, by the way, thank you for that report. That is going to be very helpful to us and I appreciate your leadership in doing that.

Mr. KUCINICH. Are you surprised by those findings, by the way?

Mr. KUHN. No, actually not. They are pretty consistent with what we are seeing. The one thing, though that was interesting in terms of that report was that, when you look at a maybe 1-year or 2-year spread of an individual Medicaid beneficiary in a program, the dental service access wasn't very great, but as you got over a longer length of time, 3, 4, 5 years, their access tends to improve. And so we would like to explore that more and would like to find some time when we can sit down perhaps with your staff and others who prepared and worked on the report to understand some of the dynamics and see if there is any hypothesis they can share with us in what we saw.

When you look at the data, it looks like you are seeing better coordination of care over the length of time, and so those will be helpful things for us to explore with you on a go-forward basis.

Mr. KUCINICH. Thank you. So when you look at the findings, will you study the pediatric dental programs in Arizona, New Jersey, and Pennsylvania, to help them improve their programs, as you are doing in at least 17 other States?

Mr. KUHN. We would be happy to go and look at those programs specifically. Certainly.

Mr. KUCINICH. Thank you. Now, what is your estimated budgetary request for next year?

Mr. KUHN. We haven't begun putting together the fiscal year 2010 budget yet, so I am not sure where we are on that at this time, but I can get back to you on that one, Mr. Chairman.

Mr. KUCINICH. Is it anywhere near \$700 billion?

Mr. KUHN. I don't think so.

Mr. KUCINICH. Now, of the estimated budgetary requests that you will have, we would like to know how much you plan on allocating to oral health, if you can do that?

Mr. KUHN. I think we can break that down. I can tell you right now though that within the Medicaid program roughly 5 percent of Medicaid spending goes for oral health. That has been fairly consistent over the last several years, so as a rough gauge that is kind of where we are at this time.

Mr. KUCINICH. Well, as you are doing your planning and reviewing, we would like you to work with us with recommendations for a legislative agenda, and let us know how we can help CMS achieve the goals to reform the pediatric dental program. If we are looking at expanding the scope of providers, the dental work force has been in decline since the mid-1990's. Current projections estimate an absolute decline in the overall number of dentists beginning in 2014. Consider also that only 2 percent of dentists are trained as pediatric specialists. This projection will be especially detrimental to communities who bear the greatest dental disease

burden, that is primarily low-income, inner-city, and rural communities.

I would like to know how does CMS propose creating a more adequate distribution of professionals to meet the oral health needs of children.

Mr. KUHN. That is a good question to pose, and that really is something that we are looking at and how we can partner with other agencies like HRSA, the Health Resources and Services Administration, and others that actually provide training dollars to schools of medicine to help in the training factor who run the work force shortage area payment programs, and so it is our hope that they will be part of our effort as we do our evaluation, and that there are ways to partner with them to work with the States and others so we can deal with some of these distribution issues.

Mr. KUCINICH. So are you exploring the potential of expanding the scope of dental providers?

Mr. KUHN. Basically, what we are right now is we are really focused on the issue at hand, the challenge that this subcommittee laid before us and the challenge we have before us as an agency, to make sure that we have sufficiency, good coverage, and great access for children with Medicaid. The issue that you are raising is one that we have talked about that I think some time in the future we would like to explore with sister agencies, but it is not in the work plan now for what we want to do in the immediate future, but it is something that we will certainly think about in the future.

Mr. KUCINICH. On our second panel we are going to be talking about focusing on prevention and disease management and how that helps to create a positive result in a short amount of time. Will you consider adopting such a model and approach to addressing oral health?

Mr. KUHN. Tell me one more time the model, Mr. Chairman?

Mr. KUCINICH. The model is approaching oral health by focusing on prevention and disease management.

Mr. KUHN. That is certainly models we want to explore, and one of the witnesses—

Mr. KUCINICH. How might you be able to do that?

Mr. KUHN. Well, one of the things that would be interesting to explore with the committee, like I said, we are not prepared yet, because we haven't finished our report, to give you any legislative recommendations.

Mr. KUCINICH. Right.

Mr. KUHN. But what I can share with you is that some of the innovations that are going on in the State are terrific, and you will hear about them on the second panel. I think the work for the folks in North Carolina, Into the Mouths of Babies, is just a terrific program. The seed money for that program was based on some grant funds that came from the Centers for Medicare and Medicaid Services.

Unfortunately, we don't have that authority right now, so I think working with you all in the future to look at some demonstrations designed to look at prevention programs for high-risk populations would be something that we could begin talking about now. I would assure you that my staff would provide any technical assistance your staff would need to help explore those options.

Mr. KUCINICH. I also, before I conclude with this round of questioning, Mr. Kuhn, I would also like you to think about another aspect of prevention and disease management, and that is with respect to parents, especially pregnant mothers. It is critical to provide dental care and education to child-bearing women and women of child-bearing age. In 2004, due to a lack of clinical guidelines, only one out of every five women who gave birth saw a dentist during pregnancy.

What are your thoughts on this, and will you consider addressing outreach and care for pregnant mothers in a prevention and disease management model?

Mr. KUHN. I would hope that the actions that we are taking now on the pediatric side would have a great deal of portability throughout the entire Medicaid program for the entire dental benefit for everyone, so that what we are doing here would not be just focused in one aspect but it would cast the net far and wide and look at the entire enterprise of what the State does in terms of delivery of dental services.

Mr. KUCINICH. But you do get the connection between dental caries from mother to child?

Mr. KUHN. Absolutely. And we are focused on the pediatric side now, but I would hope that, again, what we do here as part of this effort is across the board with the States as they go forward.

Mr. KUCINICH. And just one final question. Are you going to be studying risk-versus non-risk-based contracts nationally to offer policy guidelines to States?

Mr. KUHN. We are going to be looking at the various payment models. Yes, sir.

Mr. KUCINICH. OK. Final question to Ms. Cackley. I had asked Mr. Kuhn about this situation where MCOs are getting funding for servicing children. They are not servicing children and they walk away with a profit. Have you been able to survey that in any quantifiable way to be able to address that?

Ms. CACKLEY. That will part of our ongoing work. In our surveys to the States, we are looking at and asking them questions about their MCO contracts and how they are set up and how they are monitored.

Mr. KUCINICH. Let me tell you why that is important, because as CMS wants to be able to design a more effective model, it is important to be able to assess the degree to which the present model has not worked, and it is going to really be up to you to be able to delve deeply into this question of the providers who are gaming the system, who have found a way to be able to keep the so-called excess as profit.

I would like you to look at the MCOs' internal documentation to see if there is any way in which they encourage that. I want to find that out, so if you would do that we would appreciate it.

Ms. CACKLEY. We would be happy. That is part of our review, and we will be giving you more information soon.

Mr. KUCINICH. Because, Mr. Kuhn, if it is a policy to do that, that is something you ought to know about.

Mr. KUHN. You are absolutely right.

You know, we want to make sure that we are looking at all aspects and that we give a State the options that they need to do

their jobs, but also to make sure that we get accountability and we get the results that we all want.

Mr. KUCINICH. And when all is said and done, to both of you, this really is about children and making sure they get the dental health they need so that they have long and productive and healthy lives. I mean, that is what this is all about.

Ms. CACKLEY. Absolutely.

Mr. KUCINICH. I want to thank both of you for the work that you are doing. Please continue. We look forward to following up on this. Thank you so much.

Ms. CACKLEY. Thank you.

Mr. KUCINICH. The first panel is dismissed.

We are going to call the second panel forward.

Thank you very much for being here.

We are fortunate to have an outstanding group of witnesses on our second panel, and I want to welcome all of you here.

Ms. Susan Tucker is the executive director for the Office of Health Services for the Maryland Medicaid program. In this capacity she reports to the Deputy Secretary for the Health Care Financing Administration, which administers the Maryland Medicaid program within Maryland Department of Health and Mental Hygiene.

Over the last 18 months, Ms. Tucker has been involved in developing and implementing initiatives aimed at improving access to dental services for low-income children in Maryland.

Mr. Patrick Finnerty is Virginia's Medicaid director and has served in this position since 2002. He directs all aspects of Virginia's Medicaid and State Children's Health Insurance Programs and finance health coverage for more than 715,000 low-income persons.

Mr. Finnerty has worked in State government for 30 years. Prior to his current appointment he worked for the Virginia General Assembly's Joint Commission on Health Care for 8 years, including 4 years as the executive director.

Dr. Mark Casey is the dental director for the North Carolina Department of Health and Human Services Division of Medical Assistance. He is the current secretary treasurer of the Medicaid SCHIP Dental Association, also a member of the National Association of State Medicaid Directors Oral Health Technical Advisory Group, which has been formed to assist the Centers for Medicare and Medicaid Services in oral health policy matters.

Ms. Linda Smith Lowe has been the health policy specialist with Georgia Legal Services for the past 29 years. Georgia Legal Services serves 154 of Georgia's 159 counties, including small cities in rural areas of the State.

Ms. Lowe's involvement with the organization is focused on Medicaid and PEACH care for kids, Georgia's State children health insurance program. She also serves on several boards and works with other nonprofits on these health-related issues.

Dr. Jane Grover has been dental director and clinician for the Center for Family Health in Jackson, MI, since 2001. She is the first vice president of the American Dental Association. Between 1983 and 2001 Dr. Grover was in private practice as a general dentist. Prior to that she served as dental director of the Jackson County Health Department in Michigan. She is an adjunct faculty

member of the University of Michigan School of Dentistry and of the Lutheran Medical Center in New York, and has taught at Indiana University at South Bend.

Dr. Jim Crall is professor and Chair of Pediatric Dentistry and director of the National Oral Health Policy Center at the University of California Los Angeles [UCLA]. Dr. Crall has been actively involved in national, State, and professional policy development concerning oral health over the past 15 years. He was the principal author of Guide to Children's Dental Care in Medicaid, which was completed under contract awarded by CMS, then known as HCFA, to the American Academy of Pediatric Dentistry.

I want to thank each and every one of you for being here today. I am glad that you had the opportunity to listen to the two previous witnesses. I am sure that was instructive to you, as it was to me.

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

[Witnesses sworn.]

Mr. KUCINICH. Let the record show that the witnesses have answered in the affirmative.

As I indicated to those who testified in panel one, each witness is asked to give a summary of his or her testimony. I would ask that you try to keep the summary under 5 minutes in duration. Your written statement will be included in the hearing record.

Ms. Tucker, let's begin with you. I would ask that you please proceed.

STATEMENTS OF SUSAN TUCKER, MBA, EXECUTIVE DIRECTOR, OFFICE OF HEALTH SERVICES, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE; PATRICK FINNERTY, DIRECTOR, VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES; MARK CASEY, DDS, MPH, MEDICAL DIRECTOR, NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE; LINDA SMITH LOWE, ESQ., PUBLIC POLICY ADVOCATE, GEORGIA LEGAL SERVICES PROGRAM; JANE GROVER, AMERICAN DENTAL ASSOCIATION; AND JIM CRALL, DIRECTOR, ORAL HEALTH POLICY CENTER, PROFESSOR AND CHAIR, SECTION OF PEDIATRIC DENTISTRY, UCLA SCHOOL OF DENTISTRY

STATEMENT OF SUSAN TUCKER

Ms. TUCKER. Chairman Kucinich and members of the subcommittee, my name is Susan Tucker. I am Executive Director of the Office of Health Services for the Maryland Medicaid program. Thank you for the opportunity to testify today about Maryland's efforts to improve access to dental care for low-income children.

In February 2007 this situation was brought into acute focus in Maryland with the tragic death of Deamonte Driver. Since that time Maryland Medicaid has re-energized efforts to improve dental care for children in Maryland. In the short term, we have conducted outreach to dental and primary care providers to remind them of the dental benefits package and encourage them to refer children to appropriate dental care.

We instructed each managed care organization to verify and correct their dental provider directories, to directly assist enrollees in scheduling dental appointments, to submit weekly reports on enrollee requests for dental care, and we required MCOs to begin a series of outreach efforts to bring children in to dental care, including telephone calls, mailings, incentive plans, and dental education programs. Utilization of dental services increased from 46 percent in calendar year 2006 to 51 percent in calendar year 2007.

These approaches were an immediate way to address this very complex problem; however, in order to develop long-term strategies to improve oral health for children, we needed significant efforts on the part of dental providers, public health programs, parents, Medicaid staff, and Federal and State policymakers.

Governor O'Malley made this one of the first priorities of his administration by forming a Dental Action Committee, which included all of these key stakeholders. The committee met throughout the summer of 2007 to discuss public health strategies, Medicaid payment rates, alternative delivery models for the Medicaid program, education and outreach for parents and caregivers, provider participation, capacity, and scope of practice.

The committee made 60 recommendations. They highlighted seven over-arching recommendations for immediate action, with the goal of establishing Maryland as a national model for children's oral health care.

Major recommendations that have been or are in the process of being implemented include increased payment rates. The Governor's fiscal year 2009 budget included \$14 million as a first installment of a 3-year effort to bring Maryland Medicaid dental rates up to the 50th percentile of the American Dental Association's South Atlantic Region.

This multi-year effort is critical to attracting additional providers. The first year of the fee increase was approved by the Maryland General Assembly and was implemented on July 1, 2008. The first codes that we targeted were diagnostic and preventative codes. We paid very poorly in the past on these codes, but now compare very favorably with other State rates.

Streamlined administration. In order to ease the administrative burdens for dental providers, the committee recommended that the Department carve dental services out of the seven managed care organization service packages and administer them through a single fee-for-service administrative services organization. Our long-term goal is to link every child with Medicaid coverage in Maryland to a dental home where comprehensive dental services are available on a regular basis. We do this for pediatricians for children, and we want to do this for dentists. We believe we will be the first State in the country to implement such a project.

In the beginning of July 2008 the Department issued a request for proposals for a single State-wide vendor to coordinate and administer these benefits for Maryland Medicaid beneficiaries.

Five entities recently submitted proposals, and we are now in the process of selecting a vendor. We will be implementing this by July 2009.

Enhanced public health infrastructure. The Governor's budget included additional money for dental health public health clinics in

under-served areas. We have opened two new clinics in areas that didn't have clinics in the past, and more are planned for the upcoming year.

Increased scope of practice for dental hygienists. The legislature passed legislation during the last session to allow for increased scope of practice for dental hygienists working for public health agencies in Maryland and allowed them to provide those services offsites.

The Dental Action Committee continues to meet regularly. This is a working, action-oriented committee. They have been asked by the Secretary not to write reports that will sit on a shelf, but instead to design practical, workable initiatives and to bring all parties in the State together to solve this difficult problem. They have the support of staff throughout the Department of Health and Mental Hygiene.

One key subcommittee is developing a unified oral health message to encourage oral health literacy for all Marylanders. No child should wait until they are in pain to seek and receive dental care.

Another committee is developing a pilot program for dental screenings in schools. Still another is training general dentists on how to provide high-quality dental services to young children.

We are also fortunate that Congressman Elijah Cummings has provided a constant Federal presence by working to ensure that children have access to dental care in Maryland. He included language in the State Children's Health Insurance Program to guarantee dental benefits and introduced Deamonte's Law, which would enhance the dental safety net and work force by increasing dental services in community health centers and training more individuals in pediatric dentistry. We value his leadership in this important public health arena.

Maryland is committed to implementing the Dental Action Committee's recommendations to ensure access to oral health services for all children on Medicaid. We need to increase the number of dentists willing to see children with Medicaid and to increase the awareness of the benefits of basic oral health care among our enrollees.

Although it is too early to report on the impact of these long-term initiatives, we will regularly evaluate their success, as indicated by utilization of services, provider network adequacy, and health outcomes. We will remain flexible and will seek innovative ideas for adjusting our strategies as we move forward.

Thank you.

[The prepared statement of Ms. Tucker follows:]

**Testimony
Of
Susan Tucker
Maryland Department of Health and Mental Hygiene on Necessary
Reforms to Pediatric Dental Care under Medicaid
Domestic Policy Subcommittee
Oversight and Government Reform Committee**

**Tuesday, September 23, 2008
2154 Rayburn HOB
10:00 a.m.**

Chairman Kucinich, Ranking Member Issa and members of the subcommittee, my name is Susan Tucker. I am the Executive Director of the Office of Health Services within Maryland's Medicaid program at the Department of Health and Mental Hygiene.

I previously testified before this subcommittee in May of 2007, and I appreciate the opportunity to testify before you today about Maryland's efforts to improve access to dental care for low income children. Maryland, like all states, has a problem with access to adequate dental services for low-income children. It is a problem that extends beyond Medicaid, and therefore requires broad efforts in public health and the dental provider community. We have been working on this complicated problem for many years. In February of 2007, this situation was brought into acute focus with the tragic death of Deamonte Driver.

Since that time, the Maryland Medicaid program has reenergized efforts to improve dental care utilization. First, the Department instructed each HealthChoice¹ managed

¹ HealthChoice is Maryland Medicaid's mandatory managed care program, operated under the authority of section 1115 of the Social Security Act. HealthChoice has been operating since June of 1997, and approximately 75% of Maryland's Medicaid population are enrolled in the program, including those in Medicaid and Maryland Children's Health Program (MCHP). Administering dental benefits for children in HealthChoice is the responsibility of the seven managed care organizations (MCOs).

care organization (MCO) to verify and correct their dental provider directories, assist enrollees in scheduling dental appointments, and submit weekly reports on enrollee requests for dental care. The Department also conducted outreach to dental and somatic care providers to remind them of the dental benefits package and encourage them to refer children to appropriate dental care. Additionally, the Maryland Dental Society is helping with dental provider recruitment for the MCOs. Finally, the Department required that MCOs begin a series of outreach efforts to bring children into dental care, including mailings, incentive plans, and dental education programs in schools. Utilization² of dental services increased from 46.2% in CY '06 to 51.5% in CY '07.

These approaches were an immediate way to address this very complex problem. In order to develop long-term strategies to improve oral health for children, Maryland recognized that we needed significant efforts on the part of dental providers, public health programs, parents, Medicaid agencies and federal policymakers. Governor O'Malley made this effort one of the first priorities of his administration by forming a Dental Action Committee which included all of these stakeholders. This Committee met throughout the summer of 2007 to discuss public health strategies; Medicaid rates and alternate delivery models; education and outreach for parents and caregivers; and provider participation, capacity, and scope of practice. The Committee made 60 recommendations, highlighting seven overarching recommendations for immediate action, with a goal of establishing Maryland as a national model for children's oral health care. Major recommendations that have been or are in the process of being implemented include:

² The percent of children ages 4-20 who were enrolled in the same MCO for at least 320 days who received at least one dental service.

1. Increased Rates: The Governor's FY '09 budget included \$14 million as 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 critical in attracting additional providers. The first year of the fee increase was approved by the Maryland General Assembly and was implemented on July 1, 2008. The first codes to be targeted for increases were diagnostic and preventive codes. These codes were very poorly paid in the past and now compare very favorably with other state rates (see attachment for examples).

2. Streamlined Administration: In order to ease the administrative burdens for dental providers, the Committee recommended that the Department carve dental services out of the seven HealthChoice Managed Care Organization (MCO) service packages and administer them through a single Administrative Services Organization (ASO). The long term goal will be to ensure that every child with Medicaid coverage has access to a dental home where comprehensive dental services are available on a regular basis. We believe we will be the first State in the country to implement such a project. In the beginning of July 2008, the Department issued a request for proposals (RFP) for a single statewide vendor to coordinate and administer dental benefits for Maryland Medicaid beneficiaries. Five entities recently submitted proposals through this process, and we expect to select a vendor and implement this change by July, 2009.

3. Enhanced Public Health Infrastructure: The Governor's FY '09 budget included \$2 million to enhance the dental public health infrastructure. These funds will establish new dental public health clinics in regions of Maryland

where there are no existing dental public health facilities and will increase operational support for existing local health department dental clinics, thereby increasing access to oral health services for low-income children statewide. 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 and to provide portable school-based dental health services. Maryland is pleased that two new dental clinics opened in shortage areas this summer and that more are planned within the upcoming year.

4. Increased Scope of Practice for Dental Hygienists: Legislation was passed during the last legislative session to allow for an increased scope of practice for dental hygienists working for public health agencies in Maryland, enabling them to more efficiently and expeditiously provide services within the scope of their practice in offsite settings (e.g., schools and Head Start centers). This will help provide preventive services, such as fluoride varnish, to more children with Medicaid coverage. This legislation will take effect on October 1, 2008.

The Dental Action Committee continues to meet regularly. This is a working, action-oriented committee. They have been asked not to write reports that will sit on a shelf, but instead to design practical, workable initiatives and to bring all parties to the table to solve difficult problems. They have the support of staff throughout the Department of Health and Mental Hygiene.

One subcommittee is concentrating on developing a unified oral health message to encourage oral health literacy among all Marylanders. The emphasis will be on primary prevention and attaining and maintaining good oral health. No child should wait until they are in pain to seek and receive dental care. Another subcommittee is

developing a pilot program for dental screenings in public schools. Still another subcommittee is concentrating on training general dentists on how to provide high quality dental services to young children.

Congressman Elijah Cummings has also worked tirelessly to ensure children have access to dental care. He included language in the State Children's Health Insurance Program (SCHIP) to guarantee dental benefits, and introduced Deamonte's Law, H.R. 2731, which would enhance the dental safety net and workforce by increasing dental services in community health centers and training more individuals in pediatric dentistry. Additionally, he continues to work with UnitedHealth, a Maryland Medicaid MCO, and dental schools in Maryland to increase the pediatric dental workforce. We value his leadership in this important public health area.

Maryland is committed to implementing the Dental Action Committee's recommendations to ensure access to oral health services for all of its Medicaid enrollees through increased availability and accessibility of dentists throughout the state and increased awareness of the benefits of basic oral care among enrollees. Although it is too early to tell the impact these initiatives will have, we will continue to evaluate their success as indicated by utilization of services, provider network adequacy, and health outcomes. We will remain flexible and will seek innovative ideas for adjusting our strategies as we move forward. Thank you for giving me an opportunity today to update you on this crucial matter.

ATTACHMENT

Dental Procedures Targeted for Fee Increase in FY 2009

Proc Code	Description	MD (FY08)	MD (FY09)	DC	PA	VA
D0120	Periodic Oral Examination	\$15.00	\$29.08	\$35.00	\$20.00	\$20.15
D0140	Oral Evaluation-Limited-Problem Focused	\$24.00	\$43.20	\$50.00	N/A	\$24.83
D0145	Oral Evaluation, Patient < 3 Years Old	\$20.00	\$40.00	\$0.00	N/A	\$20.15
D0150	Comprehensive Oral Evaluation	\$25.00	\$51.50	\$77.50	\$20.00	\$31.31
D1110	Prophylaxis Adult 14 years and Over	\$36.00	\$58.15	\$77.50	\$36.00	\$47.19
D1120	Prophylaxis Child Up to Age 14	\$24.00	\$42.37	\$47.00	\$30.00	\$33.52
D1203	Topical Application of Fluoride, child (Exclude Prophylaxis)	\$14.00	\$21.60	\$29.00	\$18.00	\$20.79
D1204	Topical Application of Fluoride, adult (Exclude Prophylaxis)	\$14.00	\$23.26	\$26.00	N/A	\$20.79
D1206	Topical Fluoride Varnish	\$20.00	\$24.92	\$0.00	\$18.00	\$20.79
D1351	Topical Application of Sealant per Tooth	\$9.00	\$33.23	\$38.00	\$25.00	\$32.28
D7140	Extraction Erupted Tooth or Exposed Root	\$42.00	\$103.01	\$110.00	\$60.00	\$69.00
D9248	Non-Intravenous Conscious Sedation	\$0.00	\$186.91	\$0.00	\$184.00	\$110.00

Mr. KUCINICH. Thank you very much.
Mr. Finnerty.

STATEMENT OF PATRICK FINNERTY

Mr. FINNERTY. Good morning, Mr. Chairman and members of the subcommittee. My name is Patrick Finnerty, and I serve as the Medicaid Director for the Commonwealth of Virginia. I am pleased to appear before you this morning to review the significant changes and resulting improvements in our Medicaid and SCHIP dental programs.

In Virginia we serve about 450,000 children through our Medicaid and SCHIP programs. Soon after becoming the Medicaid Director it was clear to me that our dental program for children was not functioning very well.

As seen on slide two, fewer than 24 percent of our children received any dental service in 2003. One of the key reasons for this was that our dental provider network was inadequate. Only about 13 percent of licensed dentists in Virginia were participating in our program. Of that number, only about one-half of them were actively seeing Medicaid and SCHIP children.

While we had a pretty good idea what the problems were, we sat down with the leadership of the Virginia Dental Association and heard loud and clear that we needed to make some changes.

First, our reimbursement was very low and far below what dentists were being paid by commercial carriers. Second, they identified a number of administrative hassles that needed to be removed, such as outdated billing procedures, overly burdensome prior authorization requirements, and poor responsiveness to provider concerns.

They also felt our managed care program was not working for them. Overall, managed care has been a very successful program in Virginia; however, our dental providers had several concerns, including having to deal with multiple plan requirements, credentialing, and patients transferring between plans in the middle of treatment. Last, a significant concern was patient no-shows when patients fail to keep their scheduled appointments.

After getting a clear understanding of the changes that were needed, we created an entirely new program and declared that it was a new day for dental in Virginia. We adopted a new program name, Smiles for Children, re-branded it with a new logo, and essentially started over.

The new program was developed through ongoing and close collaboration with the Virginia Dental Association and the Old Dominion Dental Society. We were very fortunate to also have tremendous support from the Governor and the Legislature, who authorized us to implement a completely restructured program and approved an unprecedented 30 percent increase in fees.

These actions did two things. First, it gave us the necessary authority and funding to implement our new program, but, equally important, it communicated to the dental community a commitment to work with them to improve access to dental care in Virginia.

Smiles for Children was launched on July 1, 2005. Leading up to that date and ever since then, the support for the program from

the dental community has been outstanding. Dr. Terry Dickenson, the Executive Director of the Virginia Dental Association, has been and continues to be a great champion and advocate of the program.

Let me quickly review the major elements of our reform. First, we carved out dental services from the five managed care companies, and now all children have their dental services administered by one vendor, Doral Dental. Through our contractual relationship, we pay Doral an administrative fee to manage the program for us. It is a fee-for-service program wherein providers bill Doral and Doral pays the provider with funds that we make available. Neither Doral nor providers are paid on a capitated basis.

In the old program, providers had to deal with multiple credentialing requirements in order to participate. With Smiles for Children there is one streamlined process.

I mentioned earlier our providers had identified several administrative hassles in the old program. We now have industry standard administration.

Prior to Smiles for Children, Virginia dentists had little involvement in program decisions. Now we have a Virginia Peer Review Committee and a Dental Advisory Committee.

Last, by having all of the children in one dental services program, the potential for disruption of care that can result from children moving among different plans has been eliminated.

We also established a dedicated dental unit within our agency to work with providers and monitor the program.

Slide five summarizes the administrative improvements and other benefits that Smiles for Children provides for our participating dentists. I am not going to review each of them, but they represent important industry standard components of benefits administration that our dental partners were looking for.

I would like to now focus on the results of our efforts.

Following the start of our new program in July 2005, the number of participating dentists has increased 80 percent, and our network continues to expand each month. There are a handful of localities in Virginia which, prior to Smiles for Children, had no participating dentists, and now there is access to a dentist in their community.

A key indicator of our success is that a higher percentage of providers are actively billing for treatment, and our provider and patient surveys show a high level of satisfaction with the program.

More importantly, our program reforms have resulted in greater access to care for Medicaid and SCHIP children. As illustrated in slide seven, for children ages zero to 20 the percentage of eligible children receiving necessary dental services has increased 50 percent from 2005 to 2007. For children ages 3 to 20, we have seen a 55 percent increase.

We believe that these increases are the result of the two major elements of our reform—the complete redesign of the program and the 30 percent increase in fees.

Last, I just want to note that Virginia's reforms have received a good deal of national attention. Over the past few years, we have been asked to present at national meetings of the American Dental Association, the National Association of Dental Plans, the National Association of State Medicaid Directors, the Medicaid Managed

Care Congress, the National Academy for State Health Policy, and the National Oral Health Conference.

The successes we have achieved have come as a result of everyone working together for the same cause, that being increased access to dental care for low-income children. Organized dentistry has been very supportive and helpful, and they are a true partner in this. The Governor and General Assembly have given us the tools, resources, and support to make these improvements.

We recognize that, while there have been marked improvements, far more children need to be receiving dental services, and we are working toward that goal. We continue to look for further enhancements to the program and will keep this issue as a high priority in Virginia.

Mr. Chairman, that concludes my prepared testimony. I appreciate the invitation to be here today, and I am happy to answer any questions you may have.

[The prepared statement of Mr. Finnerty follows:]

Testimony
Of
PATRICK W. FINNERTY
VIRGINIA MEDICAID DIRECTOR

DOMESTIC POLICY SUBCOMMITTEE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
Tuesday, September 23, 2008
2154 Rayburn HOB
10:00 a.m.

Good morning Mr. Chairman, Ranking Member Issa and members of the Subcommittee. My name is Patrick Finnerty, and I serve as the Medicaid Director for the Commonwealth of Virginia. I am pleased to appear before you this morning to review the significant changes and resulting improvements in our Medicaid and SCHIP dental program.

In Virginia, we serve about 450,000 children through our Medicaid and SCHIP programs. Soon after becoming the Medicaid Director, it was very clear to me that our dental program for children was not functioning very well. As seen on Slide 2, fewer than 24% of our children received any dental service in 2003. One of the key reasons for this was that our dental provider network was inadequate. Only about 13% of licensed dentists in Virginia were participating in our program. Of that number, only about one-half of them were actively seeing Medicaid and SCHIP children.

While we had a pretty good idea of what the problems were, we sat down with the leadership of the Virginia Dental Association and heard loud and clear that we needed to make some changes.

- First, our reimbursement was very low and far below what dentists were being paid by commercial carriers.
- Secondly, they identified a number of administrative “hassles” that needed to be removed... such as outdated billing procedures, overly burdensome prior authorization requirements, and poor responsiveness to provider concerns.
- They also felt our managed care program was not working for them. Overall, managed care has been a very successful program in Virginia. However, our dental providers had several concerns, including having to deal with multiple plan requirements, credentialing, and patients transferring between plans in the middle of treatment.
- Lastly, a significant concern was patient “no-shows” when patients fail to keep their scheduled appointments.

After getting a clear understanding of the changes that were needed, we created an entirely new dental program, and declared that it was a new day for dental in Virginia! We adopted a new program name, *Smiles for Children*, re-branded it with a new logo, and started over. The new program was developed through ongoing and close collaboration with the Virginia Dental Association and the Old Dominion Dental Society.

We were very fortunate to also have tremendous support from the Governor and the legislature who authorized us to implement a completely re-structured program, and approved an unprecedented 30% increase in fees. These actions did two things. First, it gave us the necessary authority and funding to implement our new program. But, equally important, it

communicated to the dental community a commitment to work with them to improve access to dental care in Virginia.

Smiles for Children launched on July 1, 2005. Leading up to our launch date and ever since then, the support for the program from the dental community has been outstanding. Dr. Terry Dickinson, the Executive Director of the Virginia Dental Association, has been and continues to be a great champion and advocate of the program.

Let me quickly review the major elements of our reform.

- First, we carved out dental services from the 5 managed care companies, and now all children have their dental services administered by one vendor, Doral Dental. Through our contractual relationship, we pay Doral an administrative fee to manage the program for us. It is a fee-for-service program wherein providers bill Doral, and Doral pays the provider with funds that we make available. Neither Doral nor the providers are paid on a capitated basis.
- In the old program, providers had to deal with multiple credentialing requirements in order to participate. With *Smiles for Children*, there is one streamlined process.
- I mentioned earlier that our dental providers had identified several administrative “hassles” in the old program....we now have industry-standard administration.

- Prior to *Smiles for Children*, Virginia dentists had little involvement in program decisions; now we have a Virginia Peer Review Committee and a Dental Advisory Committee.
- Lastly, by having all of the children in one dental services program, the potential for disruption of care that can result from children moving among different plans has been eliminated.
- We also established a dedicated dental unit within our agency to work with the dental providers and monitor the program.

Slide 5 summarizes the administrative improvements and other benefits that *Smiles for Children* provides to our participating dentists. I'm not going to review each of them, but they represent important "industry-standard" components of benefits administration that our dental partners were looking for.

I'd like to now focus on the results of our efforts. Following the start of our new program in July of 2005, the number of participating dentists has increased 80%, and our network continues to expand each month. There are a handful of localities in Virginia which, prior to *Smiles for Children*, had no participating dentists....and now there is access to a dentist in their communities. A key indicator of success for us is that a higher percentage of providers are actively billing for treatment. And, our provider and patient surveys show a high level of satisfaction with the program.

More importantly, our program reforms have resulted in greater access to care for our Medicaid and SCHIP children. As illustrated in Slide 7, for children ages 0-20, the percentage of eligible children receiving necessary dental services has increased 50% from 2005 to 2007. For children ages 3-20, we've seen a 55% increase. We believe that these increases are the result of the two major elements of our reforms: the complete re-design of our dental program, and the 30% increase in fees.

Lastly, I just want to note that Virginia's reforms have received a good deal of national attention. Over the past few years, we have been asked to present our improved dental program at national meetings of the American Dental Association, the National Association of Dental Plans, the National Association of State Medicaid Directors, the Medicaid Managed Care Congress, the National Academy for State Health Policy, and the National Oral Health Conference.

The successes we have achieved have come as a result of everyone working together for the same cause....that being increased access to dental care for low-income children. Organized dentistry has been very supportive and helpful ...they are a true partner in this. The Governor and General Assembly also have given us the tools, resources, and support to make these improvements.

We recognize that while there have been marked improvements, far more children need to be receiving dental services and we are working toward that goal. We continue to look for further enhancements to the program; and will keep this issue as a high priority in Virginia.

Mr. Chairman that concludes my prepared testimony. Thank you for the invitation to be here today, and I'm happy to answer any questions you may have.

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Improving Access to Dental Care in Virginia's Medicaid/SCHIP Program

Presentation to:

Domestic Policy Subcommittee

Oversight and Government Reform Committee

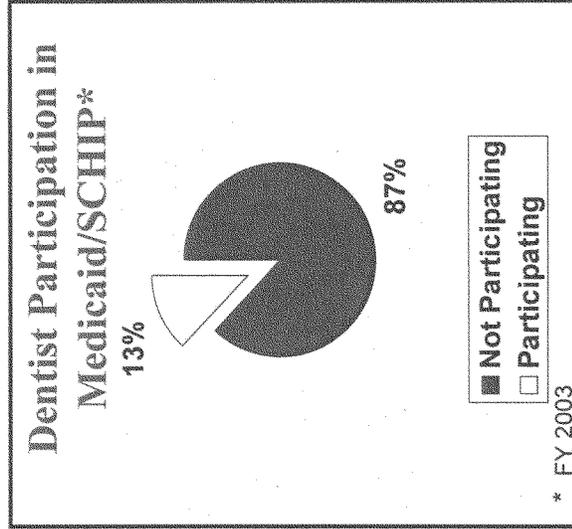
Patrick W. Finnerty, Director

Virginia Department of Medical Assistance Services

September 23, 2008

Access to/Utilization of Dental Services Needed to Improve

- In FY 2003, only 23.4% of all eligible children actually received any dental services
- Low participation of dentists in the Medicaid/SCHIP program was a major problem
 - Low reimbursement
 - Administrative “hassles”
 - Managed care concerns
 - Patient no-shows



A New Day for Dental!

Smiles for Children

- Entirely new program designed with input from Virginia dentists
 - Dental Advisory Committee
- Support from Governor and legislature
 - authorized new program structure
 - approved a 30% increase in dental fees
- Start date: July 1, 2005
- Strong support from organized dentistry



Key Program Reforms

Old Program

- Multiple Vendors
- Different credentialing processes
- Complicated Administration
- Limited local representation on program decisions
- Enrollee transfer between plans can disrupt care

Smiles for Children

- Single Vendor (Doral)
- Streamlined Credentialing
- Easy, Industry-Standard Administration
- Va. Based Peer Review Committee & Dental Advisory Committee
- All enrollees in Smiles for Children program

Value-Added Benefits for Providers

- Toll-free phone number for providers
- Call center specialists
 - Member Placement
 - Eligibility, benefits, authorizations
 - Claims issues
 - Addressing patient “no-shows”
- Multiple claim submission options.....free, electronic filing
- Timely and accurate payments
- Automated, web-integrated or live eligibility verification (24/7)

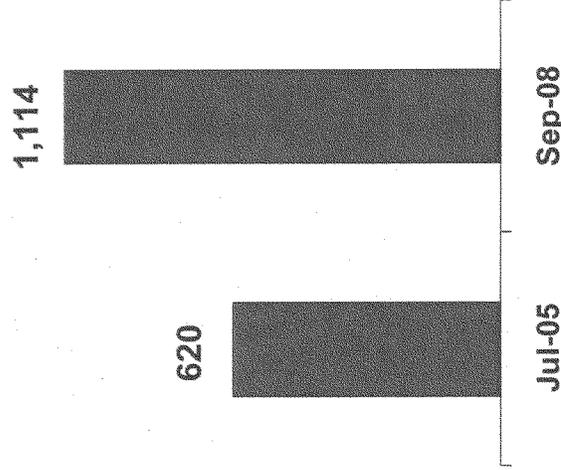


Smiles For Children
Improving Dental Care Across Virginia

Program Reforms = Increased Provider Network

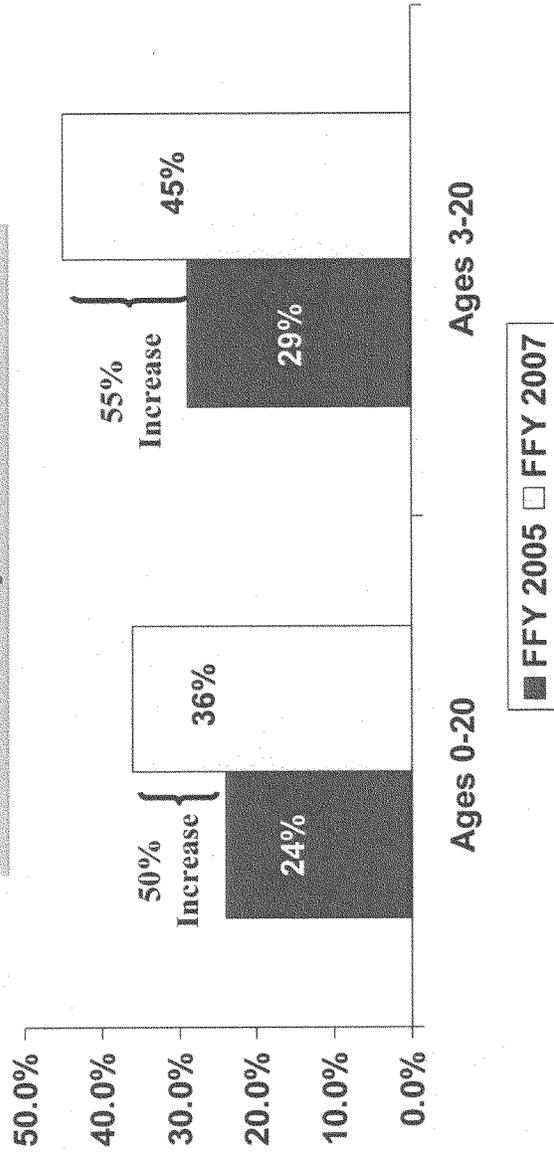
- 494 new dentists are participating (80% increase)
 - Network continues to expand
 - Several localities that had no participating dentists now have access
 - Higher percentage of contracted providers are billing for services
 - Very high level of provider satisfaction

Participating Providers



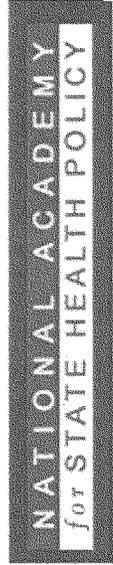
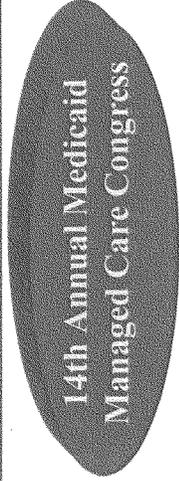
.....And Increased Access to Care

Percentage of Children Receiving Necessary Dental Care



Source: CMS 416 Report for Virginia

Smiles for Children Has Received National Attention



Mr. KUCINICH. I thank the gentleman.

We are going to declare a half hour recess. There are votes on right now. I ask the witnesses to please return in a half hour. If there are any difficulties with that, check with my staff. This committee stands in recess for a half hour.

Thank you.

[Recess.]

Mr. KUCINICH. Thank you very much. We are going to continue the hearing. The only need for a break will be if there are more votes. I want to thank you for your patience.

I would ask, with the committee now having come to order again, if Dr. Casey would proceed with your testimony.

STATEMENT OF MARK CASEY

Dr. CASEY. Good afternoon, Mr. Chairman. I would like to thank you for the opportunity to testify about reforms to pediatric oral health care in Medicaid.

My name is Dr. Mark Casey, and I am the Dental Director for the North Carolina Department of Health and Human Services Division of Medical Assistance. I am proud to highlight the Into the Mouths of Babes or IMB program, one successful strategy to improve oral health for low-income children in the State of North Carolina.

About 40 percent of all children enrolled in kindergarten in North Carolina have experienced tooth decay, and this figure can reach as high as 70 percent in some counties. As we know from the tragic death of Deamonte Driver, untreated dental disease in children can have devastating systemic consequences.

In addition, there are tremendous societal costs to families and others involved in the care of children that cannot be easily estimated—missed time at work, missed school time, time and money spent trying to find care for a child with dental problems. The lists of these costs is potentially endless.

In North Carolina we found that there were not nearly enough dental resources available to address the problem of Medicaid preschool children through traditional delivery methods, so we turned to non-dental health care professionals for a preventive strategy to manage the chronic and widespread problem of early childhood caries or cavities.

Preventive oral health care services are easily integrated into practices of primary care medical practitioners during well child visits, which occur at frequent intervals in the very first few years of life. The network of Medicaid enrolled primary care physicians in North Carolina was robust and distributed throughout all the counties of the State. All the elements of sustainability were present to translate this approach into success for a preventive program in primary care medical settings.

After demonstration and pilot projects in limited areas which were supported by Federal funds, IMB was launched State-wide in 2001. To date we have trained more than 3,000 pediatricians, family physicians, nurses, and other types of health care professionals to conduct oral evaluations and detect oral pathology, assess risk for oral disease, counsel parents and/or caregivers about oral hygiene and nutrition, and apply fluoride varnish, the safest and

most effective form of topical fluoride for the target population of children.

More than 400 primary medical practice sites are currently participating providers in the IMB. From the inception of the program, the goals of the IMB have been to increase access to preventive dental care for low-income children zero to 3 years of age, reduce the incidence of early childhood caries in low-income children, reduce the burden of treatment needs on a dental care system stretched beyond its capacity to serve young children.

As it has matured, IMB has increasingly emphasized effective dental referrals for recipients, particularly those children at elevated risk for disease.

The IMB program has resulted in a substantial increase, about 30-fold, in access to preventive oral health care services. Even in the early implementation phase of IMB, children from every County in North Carolina were receiving these services. In as many as one-third of the State's counties, no child received any preventive care in dental offices before implementation of the program. The IMB has had a positive effect on overall access for Medicaid children of all ages in North Carolina during any 1 year.

The IMB research team has conducted systematic analyses to assess the effectiveness of the program. This research has demonstrated a statistically significant reduction in restorative treatments for anterior teeth that increased with age. By 4 years of age, the estimated cumulative reduction in the number of restorative treatments was 39 percent for anterior teeth.

IMB has led to an increase of access to treatment services to the effect of referral of children with pre-existing disease at the time of the initial physician visit to a dentist. Children who are identified by their physician as having dental caries, when provided with a referral to the dentist, saw the dentist sooner than children with no dental caries who were not referred.

We have gathered evidence that physician services are not a substitute for care in the dental office but supplement preventive care being rendered by dentists for Medicaid infants and toddlers.

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 children in greatest need.

It is important to note that Federal funding played a very vital role in the success of the IMB program. Funding from the Appalachian Regional Commission, CMS, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention allowed Medicaid and partners in North Carolina to further develop our innovative approach to the prevention of early childhood caries. 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, the one-time funding initiative from CMS and other Federal agencies provides an excellent model for one strategy that could stimulate innovative thinking about new approaches to increasing children's access to dental care.

Renewal of this funding program would result in new approaches beyond the medical model developed in North Carolina and would yield oral health benefits to children enrolled in public insurance nationwide. Federal sources of funding continue to make a difference in the sustainability of IMB. Treatment services provided in the program are supported through the Federal Medical Assistance Percentage FMAP funds, matching State appropriations. Current evaluation and research efforts are supported by HRSA and the National Institutes of Health. Initial achievements and the continued success of the IMB would not be possible without the active financial support the Federal agencies have provided over the life span of the program.

The IMB partnership has moved beyond the original blueprint for the program to consider methods to improve the quality of program treatment services and extend the preventive model. Current expansion strategies focus on refining caries risk assessment tools used by both dentists and physicians and training them in their use, training general dentists to provide care for infants and toddlers, improving communication between primary care medical providers and dentists to facilitate referral when necessary due to elevated risk for dental disease, coordinating patient care to ensure parents and/or caregiver compliance with treatment regimens, and formulating oral health education initiatives targeted to parents and/or caregivers.

The IMB team believes that the future looks bright for the program as we develop new ways to extend its success. IMB advocates are also encouraged by reports of the adoption of a similar model to provide preventive services for Medicaid children in many States throughout the country. We are proud to be at the forefront of this movement and stand ready to assist other States as they plan, develop, and implement similar programs.

On behalf of the many partners in the IMB collaborative, I thank you for allowing me to bring well-deserved national attention to this important North Carolina dental public health initiative.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Casey follows:]



North Carolina
Department of Health and Human Services
Division of Medical Assistance
1985 Umstead Drive • 2501 Mail Service Center • Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Dempsey Benton, Secretary

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

Written Testimony
Submitted by
Mark W. Casey, DDS, MPH

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

Domestic Policy Subcommittee

Oversight and Government Reform Committee

Tuesday, September 23, 2008

2154 Rayburn HOB

10:00 a.m.

“Necessary Reforms to Pediatric Dental Care under Medicaid”

Mr. Chairman and Members of the Subcommittee,

1. Introduction

I would like to thank you for the opportunity to testify today about reforms to pediatric oral health care in Medicaid. My name is Dr. Mark Casey and I am the dental director for the North Carolina Department of Health and Human Services, Division of Medical Assistance. I am proud to highlight one successful strategy that an extensive collaboration committed to improving oral health for children in the State of North Carolina has chosen to address concerns about access to oral health care for a targeted population of preschool Medicaid recipients in our state.

In previous hearings, the Subcommittee has heard about the increasing prevalence of dental decay in preschool low-income children. About 40 percent of all children enrolled in kindergarten in North Carolina have experienced tooth decay; and it can reach as high as 70% in some counties.¹ The oral health of these children and their families' quality of life are greatly affected by difficult challenges in gaining access to dental care and by untreated tooth decay. Over the last decade, a number of like-minded organizations committed to finding a solution to this problem have aggressively and collaboratively pursued a strategy to deliver preventive and treatment services to Medicaid children birth to 3 years of age.

2. Development and Implementation

The architects of the strategy were concerned that a growing number of children would be so dramatically affected by the ravages of early childhood caries that they would continue to suffer from poor oral health throughout childhood and adolescence, and likely require an inordinate amount of complex treatment services to achieve acceptable oral health status. All stakeholders recognized that there were not nearly enough dental resources available to address the problem through traditional delivery methods. With this in mind, they suggested a different approach, utilizing non-dental health care professionals, in a preventive approach to the management of the chronic and widespread problem of early childhood caries in North Carolina preschool children. The medical model was chosen because preschool age children have more frequent contact with the medical care system than with the dental care system. Further, preventive oral health care services are easily integrated into the practices of primary care medical practitioners during well child visits. These visits occur at frequent intervals in the first few years of a child's life, making routine health check-up appointments an ideal time to intervene with a well-designed package of preventive oral health services. The network of Medicaid enrolled primary care physicians in North Carolina was robust and distributed throughout all counties of the state. All of the elements for sustainability were present to translate this approach into success for a preventive program in primary care medical settings.

The Medicaid program, known as "Into the Mouths of Babes" (IMB), began after a successful demonstration in a few counties in the Appalachian region of the state. Pilot

¹ NC Department of Health and Human Services (DHHS). Division of Public Health, Oral Health Section. 2004-2005 Annual K-5 Assessment of Oral Health. NC DHHS: Raleigh, NC: 2005.

studies in an expanded number of medical offices in selected sites throughout the state proved that the program would be sustainable. Based on these encouraging findings, the program was implemented statewide in 2001. From the inception of the program, the goals of the IMB have been to: (1) increase access to preventive dental care for low-income children 0 to 3 years of age; (2) reduce the incidence of early childhood caries 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. As it has matured, IMB has increasingly emphasized effective dental referrals for IMB recipients, particularly those children who are at elevated risk for dental disease.

IMB visits in the primary care medical provider office consist of: 1) oral evaluation and detection of oral pathology; 2) risk assessment for oral disease; 3) counseling of parents/caregivers about oral hygiene and nutrition; and 4) application of fluoride varnish—the safest and most effective form of topical fluoride for the target population of children. Evidence from well-conducted studies and systematic reviews suggests that counseling and fluoride varnish applications can reduce early childhood caries by more than 30%.² Physicians can provide these services in up to six visits before the child is 42 months old. To become credentialed as an IMB provider, physicians and their extenders are required to participate in a Continuing Medical Education program. To date, more than 3,000 pediatricians, family physicians, nurses and other types of health care professionals have been trained. More than 400 primary medical practice sites are participating providers in the IMB.³

3. Funding

It is important to note that 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-13186-99] for a project titled “Dental Health Promotion among Preschool Children in North Carolina’s Appalachian Region: Smart Smiles Fluoride Varnish Project.” A 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 titled “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

2 Weintraub JA, Ramos-Gomez F, Jue B, Shain S, Hoover CI, Featherstone JD, Gansky SA. Fluoride varnish efficacy in preventing early childhood caries. *J Dent Res*. 2006 Feb; 85(2):172-6.

Marinho VC, Higgins JP, Logan S, Sheiham A. Fluoride varnishes for preventing dental caries in children and adolescents. *Cochrane Database Syst Rev* 3:CD002279.

3 NC Department of Health and Human Services (DHHS). Division of Public Health, Oral Health Section, IMB Quarterly Report, January 2008.

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.

Federal sources of funding continue to make a difference in the sustainability of the IMB. Treatment services provided in the program are supported through the Federal Medical Assistance Percentage (FMAP) match to state appropriations. Current evaluation and research efforts are supported by HRSA and the National Institutes of Health (NIH). Initial achievements and continued success in the IMB would not be possible without the active financial support that Federal agencies have provided over the lifespan of the program.

4. Access to and Utilization of IMB Services

In State Fiscal Year 2008 (July 1, 2007–June 30, 2008), approximately 60,000⁴ N.C. Medicaid children ages 0–3½ (see Figure 1) made more than 130,000⁵ visits to medical offices for IMB services. Over this same period of time, about 51,000⁶ of these children did not receive any services in a dental office, even as the number of children 0–3½ years old receiving preventive services from a dentist increased over the previous year’s totals.⁷ We believe that these observations are evidence that physician services are not a substitute for care in the dental office, but supplement preventive care rendered by dentists allowing infants and toddlers, who would otherwise go without treatment, to receive important preventive care in the medical office. We also have evidence from one of the studies done by the IMB evaluation team that physicians are much more likely to refer children with untreated early childhood caries than those without, and that those

⁴ NC Department of Health and Human Services (DHHS). Division of Medical Assistance (DMA), Decision Support Report, August 27, 2008.

⁵ DMA Decision Support Unit Report, August 7, 2008.

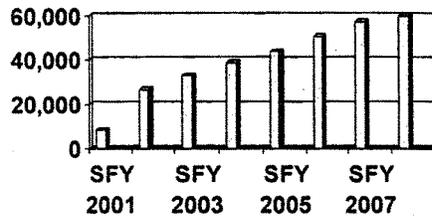
⁶ DMA Decision Support Report, August 27, 2008.

⁷ DMA Decision Support Report, September 16, 2008

who are referred as part of an IMB visit are three times more likely to make a visit to a dentist's office (36%) than those not referred (12%).⁸

⁸ Pahel BT. Referrals for dental care in medical office-based preventive dental program. Ph.D. Thesis, University of North Carolina at Chapel Hill, 2008.

**Figure 1: Number of Children
Receiving
IMB Services**



Source: North Carolina Division of Medical Assistance Dental Program Decision Support Reports, March 12, 2007, and August 22, 2008.

By enabling Medicaid children younger than 3 years of age to receive an oral evaluation, counseling, and fluoride varnish in physicians' offices, the IMB program has resulted in a substantial increase—about 30-fold—in access to preventive oral health care services. Even in the early implementation phase of IMB, children from every county in North Carolina were receiving these services. In as many as one-third of the state's counties, no Medicaid child in this age group received any preventive care in dental offices before implementation of the program. The IMB has had a positive effect on overall access measures for Medicaid children of all ages in North Carolina during any one year. For example, according to recent DMA paid claims reports, 37%⁹ of children under age 21 received at least one oral health care service from a dental provider in SFY 2008 (see Figure 2). When adding the children who received oral health care services in the IMB to the numerator used to calculate the measure, the access rate improves to 42%.¹⁰

Of course, increases in access measures for NC Medicaid recipients under age 21 are not solely a result of the growth of IMB. Dental program reforms—like removal of prior approval for many procedures, streamlined claims and billing processes (including more extensive use of electronic billing options by providers), and several reimbursement rate increases since SFY 2003—have all played a significant part in increasing access to care for children. Program reforms have resulted in gains in provider enrollment which, in turn, is an important factor behind the increases in access measures for dentists' services. Improving performance measures have occurred concurrently with steadily growing numbers of Medicaid-eligible children since 2001. The IMB, along with other program reforms, has played a large role in improving access to Medicaid pediatric oral health care in North Carolina.

⁹ DMA Decision Support Report, August 27, 2008.

¹⁰ DMA Decision Support Report, August 27, 2008.

5.

6. Figure 2: Access to Oral Health Care for NC Medicaid Children <21 (Includes Children Receiving IMB Services)

Fiscal Year	# Medicaid Eligible Children	# Children Receiving at Least One Oral Health Care Procedure	% Receiving Oral Health Care Services
2001	750,563	188,941	25
2002	780,846	228,498	29
2003	819,202	267,809	33
2004	858,750	299,800	35
2005	891,305	332,696	37
2006	948,178	372,764	39
2007	984,530*	398,499*	40
2008	1,078,121†	450,178†	42

Unless noted, all numerator and denominator data in the chart are from CMS 416 Annual EPSDT Participation Reports for Federal FY 2001–2006 (Federal Fiscal Year is October 1–September 30), available at http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp.

*Source: North Carolina Division of Medical Assistance Dental Program Decision Support Report, March 12, 2007. These data are reported for SFY 2006 (July 1, 2005–June 30, 2006).

†Source: North Carolina Division of Medical Assistance Dental Program Decision Support Report, August 27, 2008. These data are reported for SFY 2007 (July 1, 2006–June 30, 2007).

7. Research Findings

Because of its innovation and potentially large impact on the oral health of young children, an extensive evaluation of IMB was undertaken. The IMB research team has gathered evidence demonstrating that those children who received preventive services in medical offices require less dental treatment than infants and toddlers who have not received IMB services. As previously mentioned, IMB has led to an increase in access to treatment services through the effect of referral of children, who already have disease at the time of the physician visit, to a dentist. An analysis of the effectiveness of physicians' referrals indicates that children, who were identified by their physician as having dental caries when provided with a referral to the dentist, saw the dentist sooner than children with no dental caries who were not referred. 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 children in greatest need. Evaluation of Medicaid enrollees by University of North Carolina investigators as part of another project suggests that early preventive visits will lead to savings in Medicaid expenditures.¹¹

To assess the potential of IMB in ultimately reducing dental caries among young children, the research team conducted additional analyses comparing dental outcomes for

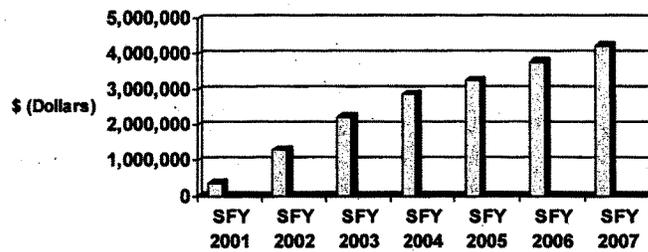
¹¹ Savage MF, Lee JY, Kotch JB, Vann WF Jr. Early preventive dental visits: effects on subsequent utilization and costs. *Pediatrics*. 2004 Oct;114(4):e418-23.

children who received at least four IMB visits and were eligible for Medicaid at 6 months of age to those of children who never received IMB services. These analyses showed a statistically significant reduction in restorative treatments for anterior teeth that increased with age. By 4 years of age, the estimated cumulative reduction in the number of restorative treatments was 39% for anterior teeth. A 12% reduction in restorative treatments found for posterior teeth was not statistically significant. It should be noted that primary anterior teeth are more likely to gain the full benefit of fluoride varnish treatments due to their eruption at an earlier age, possibly explaining the more effective caries reduction for primary incisors and canines.

8. Budget Impact

Because the costs of increasing access to preventive dental care are not currently offset by reductions in restorative treatment costs, the IMB program was not cost-saving to Medicaid during the implementation phase. However, access to care and oral health were both improved by the program. The cost-effectiveness analysis of the program has been deferred until the sample size of children receiving greater exposure to IMB services (i.e., four or more visits) can be increased. The research team plans to use estimates of cost benefits in terms of reduced need for dental treatment for children up to 7 years of age. The overall increase in access to care, and other beneficial effects of the IMB, have been achieved with a small investment in terms of Medicaid expenditures compared to the overall oral health budget. For example, expenditures for the IMB program in SFY 2007 totaled approximately \$4.2 million¹² out of total expenditures of roughly \$160 million¹³ dedicated to the funding of children’s oral health care.

Figure 3: IMB Services Expenditures



Source: North Carolina Division of Medical Assistance Dental Program Decision Support Reports, December 13, 2006, and December 18, 2007.

9. Growth, Sustainability, and Future Direction

The IMB partnership has moved beyond the original blueprint for the program to consider methods to improve the quality of program treatment services and extend the

¹² DMA Decision Support Report, August 22, 2008.

¹³ DMA Decision Support Report, January 10, 2008.

preventive model. Current expansion strategies focus on: 1) refining caries-risk assessment tools used by both dentists and physicians and training them in their use; 2) training general dentists to provide care for infants and toddlers; 3) improving communication between primary care medical providers and dentists to facilitate referral when necessary due to elevated risk for dental disease; 4) coordinating patient care to ensure parent and/or caregiver compliance with treatment regimens; and 5) formulating oral health education initiatives targeted at parents and/or caregivers. The IMB team believes that the future looks bright for the program as we develop new ways to extend its success. IMB advocates are also encouraged by reports of the adoption of a similar model to provide preventive services for Medicaid children in many states throughout the country. This good news is an affirmation of our belief that the medical model works. We are proud to be at the forefront of this movement and stand ready to assist other states as they plan, develop, and implement similar programs.

On behalf of the many partners in the IMB collaborative, I thank you for allowing me to bring well-deserved national attention to this important North Carolina dental public health initiative.

The IMB project was carried out through a collaborative partnership of the North Carolina Academy of Family Physicians, Inc., the North Carolina Pediatric Society, the Division of Public Health—Oral Health Section, the Division of Medical Assistance, the North Carolina Dental Society, North Carolina Early Head Start and Head Start, and the University of North Carolina—Chapel Hill Schools of Dentistry and Public Health.

Mr. KUCINICH. Thank you very much, Dr. Casey.
Ms. Lowe, please proceed.

STATEMENT OF LINDA SMITH LOWE

Ms. LOWE. Good morning, Mr. Kucinich. Thank you, Mr. Chairman. My name is Linda Lowe. I really appreciate the fact that you are having these hearings on this critical topic of our children.

Like children in most States, Georgia's low-income children have poor dental health. In 2005, 56 percent of our third graders had tooth decay, and 27 percent of the children had untreated decay. School officials continue to say that a major reason for students' absences from school and their poor academic performance has to do with their lack of dental care.

Getting oral health care right under Medicaid could make an enormous difference for this generation of children. In 2005, 63 percent of Georgia's children had either Medicaid or PEACH Care, which is our State child health insurance program. Many other children were eligible but not enrolled.

Your staff asked me to highlight Georgia's experience with dental care for children over the last decade. Georgia's story is one of somewhat successful multi-year efforts that saw some dentists accept Medicaid patients and produced noteworthy increases in utilization rates for children. Unfortunately, it also shows that budget cutbacks can too easily reverse such advances, and that moving to capitated managed care is no panacea.

Just a little history: in 1999 advocates and dentists raised an alarm about Georgia's poor and diminishing access to oral health care for children. Medicaid dental reimbursement was about 30 to 40 percent of average customary fees. A Statewide referral hotline had located only 257 dentists willing to take new Medicaid patients, far too few to meet the need in our State, which is the largest geographically east of the Mississippi.

In response, the State very wisely enacted a rate increase, raising reimbursement to about \$0.50 on the dollar. It also took concrete steps to simplify billing.

Two years later, the State raised rates to the 75th percentile, and afterward provided an inflationary increase. Also at that time Georgia moved to more electronic claims processing with instant online information about patient eligibility and claim status.

During this period, more dentists began to accept Medicaid patients. Between 2000 and 2005, the number filing at least one claim per week increased by 57 percent to over 1,000. Also, a mobile dental service, which was the innovation of a Georgia practitioner, started operations and now serves children at school in 76 counties.

Over 5 years, our children's utilization rates, as shown on the CMS 416, made steady progress. The proportion of children receiving any dental service, preventive dental services, and treatment services rose from below 20 percent to about one-third of all children, and it really seemed that children's oral health care was on the right track.

Then in fiscal year 2004 a State budget crisis led officials to eliminate reimbursement for a number of restorative dental services, cutting a total of 7.5 percent from the dental budget. In 2005,

although the proportion of children receiving preventive dental services continued improving slightly, the proportion receiving treatment plunged from 34 percent to 19 percent and went down again the next year to 17 percent.

In mid-2006, announcing its intention to save money and to improve access, Georgia required most Medicaid and all PEACH Care children to enroll in one of three capitated managed care organizations that we call CMOs. The CMOs would be responsible for almost all of their services, including dental care.

At first the CMOs kept fees where they were, but that soon changed when they saw higher than expected utilization eating into their profits. They required more prior approvals, adjusted fees, and began closing networks. Two of them terminated their contracts with the dental organization that had served over 40,000 children.

Dentists complained that the CMOs and their subcontractors have added new levels of administrative difficulty, not to mention cost. In addition, some dentists say it is harder to find specialists who will accept referrals. Although the CMOs list large networks of dentists, data from the State show that large number of the CMOs' dentists have not filed a single claim.

It is too soon to know whether CMOs are making a difference in children's health care one way or the other. The first year of implementation is the latest for which we have data. The utilization rates remain close to the same as the year before CMOs began operation when treatment rates had dived. It will take systematic data collection and analysis to see how well children are actually doing.

It would be worth evaluating the mobile school-based approach which claims 65 to 70 percent of their Medicaid children complete treatment, which they say is far more than the children in their office practice, which includes children with other kinds of insurance. While it is not the traditional model of a dental home, it helps solve the problems of inadequate transportation, a parent having to forego a day of earnings to take children to the dentist, and the no-shows that hinder efficient operations in a dentist's office.

My testimony that is written lists a number of recommendations, some of which address issues I haven't had time to talk about here, but, once again, I want to thank you for your attention and for your concern about the problem with children's oral health.

[The prepared statement of Ms. Lowe follows:]

**Testimony
Of
Linda S. Lowe, MS**

**Domestic Policy Subcommittee
Oversight and Government Reform Committee
Tuesday, September 23, 2008
10:00 a.m.**

***“Hearing on Necessary Reforms to Pediatric Dental Care under
Medicaid”***

Good morning, Chairman Kucinich, Ranking Member Issa and Members of the Subcommittee. My name is Linda Lowe. I am the Health Policy Specialist for the Georgia Legal Services Program which serves 154 of Georgia’s 159 counties, including the small cities and rural areas of the state. I have worked with GLSP for 29 years (now part-time) focusing on health issues, particularly Medicaid and PeachCare for Kids, our State Child Health Insurance Program. I also work outside GLSP with other nonprofits on these matters and serve on the boards of several community organizations.

You have received information from many other sources about the disgraceful truth that poor oral health among low-income children in our nation is all too common. Although Medicaid’s EPSDT program is a powerful tool for addressing children’s needs, most states have not yet fulfilled the promise of adequate dental care. The need to hold ourselves and our state programs to high standards is great, but we often lack the analytical data to facilitate meaningful evaluation, oversight and planning. In this light, my testimony will address Georgia’s efforts to improve dental care during the past decade after long neglect of the oral health of its children.

Context.

Some comment about Georgia's situation is warranted. Medicaid and PeachCare are major insurers of Georgia's children. Their success in addressing dental needs is crucial to child well-being.¹ In 2005, nearly half (49.5%) of our children had Medicaid, and another 13.3% had PeachCare.² (The numbers of enrolled children declined beginning in 2006, due in large part to new federal and state verification requirements that erected barriers for the families of many eligible children. Even before then, at least 200,000 children were eligible, but not enrolled.) Geographically, Georgia is the largest state east of the Mississippi River and suffers from a maldistribution of health care providers that restricts access for many people regardless of income or insurance. High fuel prices and the dearth of public transportation in rural areas mean ancillary services like Medicaid transportation are essential to achieving meaningful access to care. Parents' own inexperience with regular dental care likely hinders access for children; Georgia Medicaid pays only for emergency dental care for adults and covers relatively few parents at all because of restrictive financial eligibility criteria. Another impediment is that many parents work at low-wage jobs offering no paid leave, so taking a child to a dentist during business hours can mean a smaller paycheck or even job loss in our employment-at-will state. Additionally, because Georgia provides no guaranteed period of eligibility, interruptions in care occur. Despite Georgia's ranking in per capita income near the middle nationally, it is a low-tax state.

Past Trends in Children's Dental Care.

Georgia began to raise payments to providers in FY 1999 in hopes of enticing more of them to participate in Medicaid. (See the detailed discussion in the next section.) The positive news so far from Georgia is

that the proportion of Medicaid-covered children receiving any dental service doubled from 18% in FY 2001 to 36% in FY 2007, a noteworthy improvement, but still very short of what the numbers would be if children received the semi-annual visits dentists recommend. While only 16% received preventive dental services in FY 2001, by FY 2007, 34% received such services. The more discouraging news for that period is about treatment: although the proportion of children receiving dental treatment rose steadily from 18% in FY 2001 to a high of 34% in FY 2004, it fell sharply to 19% in FY 2005 and then back to 18% in FY 2007.³ DCH has said it also is concerned about these trends and is planning a conference with various stakeholders (DCH, CMOs, dental providers and associations, public health, and advocates) to look at the issues and begin steps to improve dental access and care.

Teachers continued to report dental problems as a major reason for students' absences from school and poor academic performance. Georgia's Third Grade Oral Health Survey in 2005 documented that 56% of all the children surveyed had tooth decay, and 27% had untreated decay. Researchers noted that low-income children were far more likely to have decayed teeth than others and also found that children with health coverage and those with a dental visit in the prior year were more likely to have good oral health.⁴ About 40% of all the children had dental sealants. Augmenting Medicaid and PeachCare, Georgia's Department of Human Resources Public Health Division operates a dental sealant program for schools and Head-Start centers providing sealants for about 8,100 low-income children in FY 2007. For Medicaid and PeachCare, utilization data are limited after FY 2007 (July 2006-June 2007), but will be of great interest because of several factors, including Georgia's mandatory enrollment of most children in Medicaid/PeachCare-only capitated managed care beginning in June of 2006. A chronology of changes follows.

A Decade of Change Affecting Children's Dental Care.⁵

- From the mid-1980s until FY1999, Medicaid dental reimbursement was flat. Dentists' reimbursements dropped to 30 to 40% of average customary fees. The POWERline, a statewide referral service, conducted a survey and found only 257 dentists providing services to Medicaid recipients.⁶
- State officials became aware that a lawsuit over the lack of access could result in federal sanctions. Advocacy groups joined with dentists to raise an alarm over the poor oral health conditions of Georgia children. The state enacted a 33% increase on 64 codes and a 10% increase on the remainder of the codes for FY 1999. This raised reimbursement to about 50 cents on the dollar, and DCH also made several administrative changes like using the standard ADA claim form and CDT codes.
- Also in 1999, Georgia began enrolling children in PeachCare for Kids, the then new SCHIP program. Dental coverage and fees were equal to those for Medicaid, and providers were deemed enrolled in both programs if they were enrolled in Medicaid.
- The FY 2001 budget increased fees to the 75th percentile, equaling South Carolina's Medicaid reimbursement. In exchange for this more realistic payment, the Georgia Dental Association committed to increase the number of participating providers and initiated the "Take Five Program" which succeeded in greatly expanding the enrollment.
- Despite a tight budget, the state continued its commitment to improving access, raising fees again by 3.5% for FY 2003.
- In 2003 and 2004, Georgia transitioned from EDS to ACS for processing and paying claims. The result was a better system with more electronic claims processing and easier-to-access online information about patient eligibility and claims. However, the

lengthy and rocky start-up discouraged providers in all categories who received late or no payments for long periods and had claims denied without justification.

- For FY 2004, a budget crisis led the state to eliminate 11 dental codes for restorative services from Medicaid and PeachCare, cutting a total of 7.5% from the dental budget.
- Advocates and GDA had to fend off a threat to eliminate PeachCare dental coverage in FY 2005 due to budget shortfalls. Children were locked out of coverage for three months for allegedly late premium payments until public outcry resulted in the policy's finally being relaxed.
- In FY 2006, the state cut PeachCare dental services, making them far less comprehensive than Medicaid's. Two children in the same family with the same needs seeing the same dentist might be eligible for different services because the six year-old had PeachCare and the five year-old had Medicaid.
- Beginning June 1, 2006 and phasing in by October, Georgia required most children with Medicaid and all children with PeachCare to enroll in capitated managed care organizations ("CMOs") responsible for almost all their services, including dental care. (Children receiving Medicaid based on disability and those in foster care or receiving adoption assistance are excluded and continue to receive care under the fee-for-service system.) A benefit of the new system was that the CMOs planned to again cover the same services for children with PeachCare as for children with Medicaid, but the transition to CMOs created other problems for patients and providers that are discussed in the next section.
- In FY 2007, the GDA and advocates persuaded the state to fund essential dental services for pregnant women based on research

findings that treating the mother's dental infections leads to healthier babies and fewer problem births.

- Federal delays in reauthorizing and funding SCHIP created major consternation about the FY 2007 and 2008 PeachCare budgets. The legislature came close to making major cuts in PeachCare eligibility, dental services and other aspects of the program, although after major advocacy efforts, the legislation died on the last night of the session. As it was, enrollment was frozen for a time and finally capped, although the cap has not yet been reached.
- In 2008, the General Assembly also passed HB 1234 which, among other things, requires CMOs to pay claims promptly and to allow additional dentists into their networks in defined shortage areas. It attempts to clarify who pays when there is confusion over which CMO has responsibility for the patient.⁷
- For FY 2009, legislators authorized a 2.5% dental fee increase and required that it be passed along to dentists by the CMOs. Although Gov. Perdue signed the budget bill, he is delaying the rate increases for at least a year due to a sharp downturn in tax receipts that has created a large deficit for FY 2009 and FY 2010.
- A new budget threat in addition to the state revenue shortfall now looms. Georgia has been collecting about \$90 million a year in quality assessment fees from the CMOs. Because the Deficit Reduction Act and accompanying regulations require the state to collect fees from commercial managed care entities if it wants to continue collecting from the Medicaid/PeachCare CMOs after September 2009, the state now faces the choice to expand the base for the fee, raise taxes, or make cuts. Once again, dental care for PeachCare members would be on the chopping block, as would any Medicaid fee increases.

Despite the budget ups and downs, this period reflected a commitment on the part of state officials to improve dental access by raising reimbursement rates. A study from the Georgia Health Policy Center and the Department of Human Resources cited earlier indicates that between 2000 and 2005, the number of Medicaid “participating” dentists increased by 65.2% from 839 to 1,287 and the number of “active” dentists increased by 56.6% from 598 to 1,056. Participating dentists filed at least one claim per year, and active dentists filed at least one per week.⁸ DCH’s figures show that In FY 2006, 1,641 dentists filed at least one claim for children’s dental care.⁹

Dental Care under CMOs.

When Georgia embarked on its plan in 2006 to enroll most Medicaid patients and all children with PeachCare in capitated managed care, officials stated goals of saving money, making the budget more predictable and improving health by increasing access to appropriate health care services. Officials divided the state into six regions and awarded contracts to three bidders, Amerigroup, Peach State (Centene Corporation) and WellCare. WellCare operates statewide. Both of the other two operate in the Atlanta region, thus allowing patient there to choose among three. Patients in the other regions must choose either WellCare or one of the other two. If patients fail to choose within 30 days, they are assigned automatically.

All of the CMOs opted to sub-contract their dental services either to Avesis or Doral. CMOs required dentists to sign contracts with these two providers if they wished to participate in Medicaid and PeachCare. Fees remained unchanged at first, but would soon be altered.

Whether or not the new arrangement adds value, it created two extra layers of bureaucracy, both of which siphon off money that could

have gone to compensate providers of care. It also means that instead of dealing with the single entity that used to handle all Medicaid and PeachCare coverage policy and claims, they now have to cope with two or three. One dentist with a substantial Medicaid practice says he has three color-coded charts on his treatment room walls so that he can tell how to provide services for each patient: red for Doral, blue for Avesis and black for “not covered.” He also treats some children with SSI who remain in regular fee-for-service Medicaid, but he says it is much easier to understand the regular Medicaid rules and to get claims paid. To deal with the CMOs, he also says he has had to hire better educated hygienists and dental assistants at higher rates of pay so that they can understand and apply the complicated rules.

The CMO startup involved many “glitches,” and some of them persist. An obstacle that has continued is the difficulty providers have faced in confirming at the time of service a patient’s eligibility for Medicaid or PeachCare and verifying that patient’s enrollment in a particular CMO. Patients carry plastic cards that must be recognized in both the state’s system (the Georgia Health Partnership or GHP system) and the CMOs, where there is often a delay. Too often patients have learned upon arriving for their appointments that the system does not show them as eligible. Some have been turned away. The dentist referred to above describes the problem this way:

Before the advent of the CMOs, ACS handled the management of the Medicaid program in the state of Georgia. When ACS took over the Medicaid program in 2003, there were issues that, at first, were huge bumps in the road but eventually were ironed out. By the end of 2003, ACS ran the Medicaid program smoothly with few errors in payment and never a question regarding eligibility. Checking a member’s eligibility was easy through the GHP web portal. Active status and limitations were

readily available through one easy step. Eligibility for patients was checked by one front office staff member the day before the patient's appointment. If a child was not eligible, they were not seen as we knew that ACS would not pay if the GHP website stated their status was inactive.

Since the CMOs have taken over the management of the Medicaid program, checking eligibility has turned into a job that requires two to three front desk staff members. A child's eligibility must be checked through the GHP website as well as the Doral website (for WellCare and Amerigroup patients) or the Avesis website. It requires a total of three printouts as opposed to one, which consumes more time and resources. When a child is showing active on the GHP website but inactive on the CMO website, we still see the patient because the GHP site is accurate while the CMO site might not have been updated. When this occurs, though, we have to bypass the transmission of an electronic claim for payment and revert to a paper claim with a copy of the child's eligibility attached to show the CMO that the child is active according to the state. Many times, the claim is still denied by the CMO, despite the attachment of GHP eligibility, which as of July 1, 2008 must be honored as evidence of a child's active or inactive status (because of HB 1234), regardless of what the CMO website states. It is very time consuming to re-file two or three times a claim that should have been paid the first time with an attachment. It requires the employment of one person whose job is dedicated to Medicaid posting and re-filing. The verification of eligibility requires the time of two to three front desk staff members throughout the course of the day.

The confusion over eligibility is one problem the General Assembly seeks to address through this year's passage of HB 1234. It designates the GHP website as the authoritative source on eligibility.

After beginning operations, the CMOs quickly became alarmed by what they saw as excessive utilization of dental services that threatened their profitability, claiming they had budgeted for lower amounts based on data the state had provided for their bids. Beginning in early 2007, Doral and Avesis, on behalf of the CMOs, started sending letters to dentists outlining significant changes designed to drive down service use and payments. They listed services for which they would begin requiring prior approval, announced fee reductions for certain procedures, closed enrollment of new providers except for specialists, and soon began terminating contracts for some dentists. In September of 2007, for example, both WellCare and Peach State terminated from their networks Kool Smiles PC, a dental group provider that had served a total of 44,500 of their patients. Amerigroup announced a plan to subcapitate dental services in some counties and for some patients, but later withdrew it and cut reimbursements instead. It later rescinded the rate cuts. (A summary of announced changes prepared by the Georgia Dental Association and copies of letters are available.)

Assessing the adequacy of the current networks and the degree of meaningful access is difficult because of lack of information, such as encounter data and detailed monitoring reports. According to the Department of Community Health, the CMOs claim the following slates of providers:¹⁰

Dental Specialty Types	Peach State	Amerigroup	WellCare
Anesthesiology*	20	32	27
Endodontics	9	3	3
General Dentistry	1,368	463	1,724

Oral and Maxillofacial Surgery	137	66	100
Orthodontics and Dentofacial Orthopedics	32	22	21
Pediatric Dentistry	345	78	307
Periodontics	37	5	27
Prosthodontics	11	4	4
Total	1,959	673	2,213

*The GDA says anesthesiology is not a recognized dental specialty

Other information sheds additional light on the extent to which dentists are actually providing care to Medicaid patients. GDA reports that in the fall of 2007, it surveyed the 870 dentists listed as dental providers by the CMOs. It concluded that about 19% were no longer accepting any new Medicaid or PeachCare patients, 55% were not accepting new Amerigroup patients, 58% were not accepting new Peach State patients, and 64% were not accepting new WellCare patients. Citing the results of the survey, the Georgia Dental Task Force recommended obtaining claims and encounter data to further document actual participation.¹¹

In May 2008, the Department of Community Health, responding to an open records request from a dentist, supplied data on the numbers of dental claims filed per provider from July 1, 2006 through June 30, 2007 (FY 2007) in fee-for-service Medicaid and under each CMO. The numbers are broken down as 1-50, 51-250, 251-500, and 500+ claims. In all cases, a small proportion of dentists performed a large percentage of the dental procedures. In fee-for-service, 20% of dentists performed

90% of procedures. Proportions for the CMOs were Amerigroup, 15%; Peach State, 24%; and WellCare, 26%. It is noteworthy that for two of the CMOs, the numbers of dentists who filed at least one claim (Peach State – 654 and WellCare – 854) were far lower than the numbers they listed in their networks as shown in the table above. Amerigroup's numbers were close to the same, with 644 dentists filing at least one claim. Advocates have heard reports of CMO members having difficulty locating providers on the CMO lists who will accept them as patients. However, DCH says it has not been able to substantiate the majority of complaints about inability to locate providers who will accept CMO patients; staff have made "secret shopper" calls and report they would have been able to schedule appointments. Rigorous data gathering would be helpful. A prominent dentist from a north Georgia community whose practice used to consist of a quarter Medicaid patients says he has discontinued accepting Medicaid, but still gets referrals from the CMOs even though he has not participated in over a year.

A matter that Georgia should address for patients who require dental care is Medicaid transportation. For some years, Georgia has used a capitated broker system which sometimes fails to respond to practical needs. A dentist complained last week that some of his patients who have to come from miles away must be ready for their transport at 3:00 a.m. and arrive at his office at 6:30 a.m., long before he opens for business.

Obtaining specialty care is another difficulty. A dentist in a small town whose practice is 25-30% Medicaid says that since the entry of CMOs, he has to send children needing a pediatric dentist an hour and a half to two hours away now because the closer-to-home practitioner who used to take his patients refuses to deal with the CMOs. Calls to the

POWERline seeking pediatric dentists in rural areas reinforce the concern about specialty care.

One promising practice that bears evaluating is a model called Help a Child Smile, the innovation of a Georgia dentist who still maintains his original practice. HCS reports that its mobile dental offices deliver services to children at school in 84 school systems (76 counties), providing screening, preventive care and treatment.¹² HCS accepts Medicaid and PeachCare, private insurance, and cash. It reports a high rate of completed treatment and has earned enthusiastic support from school counselors and nurses who say children are benefitting greatly from the care. An attempt by CMOs to restrict HCS's reach as part of last year's cutbacks met with a major campaign of resistance from school personnel and parents. The shortcoming of the model is that the mobile offices are not always present in the community as a dental home for the children. It can be difficult to get a child's records to a local dentist when care is urgently needed (although electronic records could be a remedy), and some dentists in fixed practices dislike the competition. However, it may be a creative solution to the problems of inadequate transportation, a parent having to forego a day of earnings to take children to the dentist, and the "no-shows" that hinder efficient operations in a dentist's office.

We do not know yet whether outcomes for children are better or worse under CMOs. Their contracts with the state require them to comply with EPSDT requirements and to submit plans for how they will do so. The CMOs are required to undertake internal quality assessment and improvement measures and to submit data that could help the state determine whether or not they are meeting their obligations and how patients are faring, but little is publicly available so far. DCH has conducted surveys of providers and reports that their complaints about

access to CMO staff who can resolve problems, claims payment, and web site concerns are being addressed. It also reports that CMOs' internal reviews have identified quality of care issues such as undiagnosed decay, multiple fillings of the same tooth, and injury to tooth or gums during procedures.¹³ (At the same time, peer consultants reviewing fee-for-service provider records found use of excessive amounts of local anesthesia for low-weight patients, use of stainless steel crowns instead of less expensive restorations, lack of documented medical history, and improper billings.)¹⁴ Last year, DCH fined Peach State \$3.7 million for improperly delaying care by failing to act timely on prior approval requests. We are aware that CMS has conducted an audit here, but we have not seen a draft. Voices for Georgia's Children has a study underway to examine and evaluate process data from the CMOs and is including a measure for the number of children receiving a preventive dental visit in the course of a year.¹⁵ Advocates hope to begin in this third year of CMO implementation to see encounter data and other information to enable us to understand better whether or not the state is making progress in improving children's oral health.

Recommendations:

- Make oral health for children a high priority for CMS and address it as such with states.
- Encourage states to adopt options such as 12 months' continuous eligibility for children so that their care is not interrupted by episodic loss of coverage. No matter how good dentists and CMOs are, they cannot manage care effectively without being able to complete screenings and treatment.
- Similarly, encourage states to smooth out income limits so that children in the same family can qualify for Medicaid or SCHIP regardless of age. In Georgia, a family with income at 125% of

poverty can have a four year-old in Medicaid and a six year-old in PeachCare. Even though Georgia wisely has matched the two programs as to services and payments, there are still two different eligibility systems, and children can experience breaks in coverage when they age from one program to the other. Raising Medicaid limits to 150% of poverty, for example, could help resolve the problem at least for families with children over age one.

(Advocates worked successfully for passage of a measure to do this, but a previous governor impounded the funds to deal with a budget shortfall.) In addition, require states to create seamless transitions between Medicaid and SCHIP.

- Encourage states to make it possible for more parents to qualify for Medicaid and to cover essential dental services for them so that the family is more likely to understand the importance of and seek regular dental care.
- Hold states to “equal access” payment rate requirements and accessibility standards sufficient to achieve maximal oral health for children whether they use fee-for-service or capitated managed care.
- Require states to show that their ancillary systems like Medicaid non-emergency transportation and case management support adequate access to services for all patients.
- Require states to publicly report data measured against goals on a regular basis to enable advocates and other stakeholders to track progress, raise questions, and identify opportunities for improvement. This should include information regarding focused studies and improvement plans.
- Expand the focus of data collection to examine oral health outcomes for children rather than just process measures.

- Improve monitoring of the “treatment” feature of EPSDT for which there is little systematically collected data in every category of service, including dental care.
- Evaluate promising practices, share findings with states, and offer technical assistance.

Once again, thank you for this opportunity to speak with you today. I join many others in being gratified and encouraged by your concern and commitment regarding this critical issue for children.

¹ Georgia’s Medicaid income limits for children are as follows: Infants < 1, 200% of FPL (185% if not born to a mother with Medicaid for the birth); Ages 1-5, 133% of FPL; Ages 6-18, 100% of FPL. PeachCare covers children over these limits, but below 235% of FPL. (Georgia also covers children who qualify for Medicaid because they receive SSI, children in foster care or receiving adoption assistance, and Katie Beckett children.)

² *Analysis of Access to Dental Care Provided through Medicaid and PeachCare (SCHIP), Service Trends and Patterns, CY2000/SFY2001 through CY2005/SFY2006*, Georgia Health Policy Center with Georgia Department of Human Resources, Division of Public Health, December 2006, p. 7.

³ Georgia Department of Community Health, Division of Medical Assistance, “Historical Utilization Trends Based on CMS 416 Data,” 2008.

⁴ It should be noted that utilization for the higher-income PeachCare children is better than for Medicaid children, although service coverage and payment rates have been exactly the same during most years. For example, in FY 2003, utilization of any dental service for PeachCare children was 49% versus 31% for children with Medicaid. Other years show similar differences. Utilization rates for both vary considerably among sections of the state.

⁵ Compiled with assistance from the Georgia Dental Association.

⁶ The POWERline is operated by the Healthy Mothers Healthy Babies Coalition of Georgia and receives thousands of calls per year from people having difficulty finding health services. Calls seeking dental services are among the most frequent, and it was their overwhelming numbers in the late 1990s that led to successful advocacy to raise Medicaid dental fees. Current callers include parents seeking care for children during the month or so it takes to complete entry into a CMO after becoming eligible for Medicaid or PeachCare.

⁷ HB 1234 signed as Act 585. http://www.legis.ga.gov/legis/2007_08/sum/hb1234.htm

⁸ *Analysis of Access to Dental Care*, p. 7.

⁹ Georgia Department of Community Health, Annual Report, Fiscal Year 2006.

¹⁰ Georgia Department of Community Health, September 18, 2008.

¹¹ Georgia Dental Task Force, *Shining the Light on the State’s Dental Education Needs*, A report and recommendations submitted by the Georgia Dental Task Force to Medical College of Georgia President Daniel W. Rahn, MD, 2008.

¹² Help a Child Smile Mobile Dental Program. <http://www.helpachildsmile.org>.

¹³ Data supplied by the Department of Community Health, September 17, 2008.

¹⁴ *Ibid.*

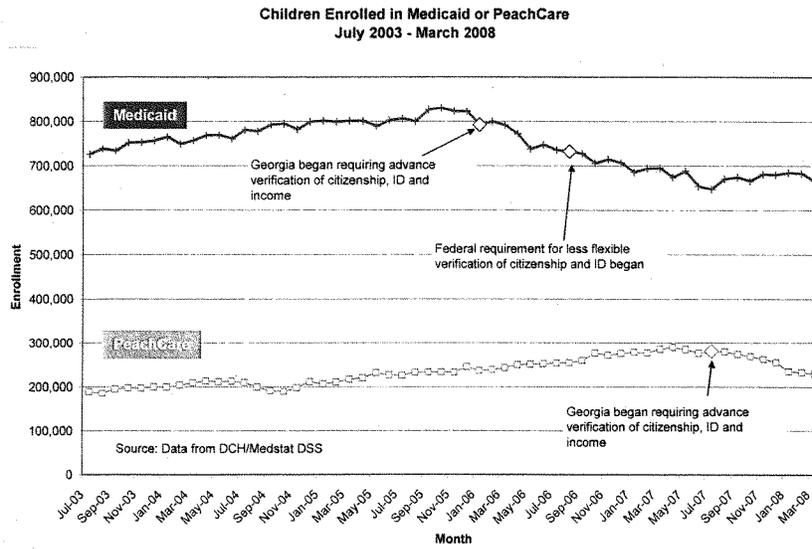
¹⁵ Jennifer Edwards, Lisa Duchon, and Jodi Bitterman, Health Management Associates, *Quality of Care and Health Outcomes for Children in the Georgia Families Program*, Report for Voices for Georgia’s Children, August 1, 2008 (draft for review, not yet published).

Red Tape Keeps Eligible Children Out of Medicaid & PeachCare

Despite population growth, fewer Georgia children have Medicaid than in 2005. This drop is largely due to new requirements for advance verification of citizenship, identification and income that went into effect starting in 2006. Federal law changed the citizenship and ID rules. It was the state's decision to require advance proof of income for children's Medicaid. Most of the children are likely eligible, but their families have difficulty obtaining the necessary paperwork.

PeachCare for Kids enrollment has also dropped since July of 2007, when similar requirements were imposed for children in that program.

In 2007, a monitoring project involving an advocate, a social worker and a pediatrician found apparently qualified children whose families had experienced problems getting or retaining Medicaid or PeachCare for them. Many had missed receiving needed medical care. Hospital emergency room visits for children without insurance reportedly rose substantially.



Note: These are raw numbers with no lag factor applied. Medicaid enrollment for later months will change slightly due to retroactive eligibility. Also, some fluctuation has occurred because of DCH removal of duplicate enrollment ID numbers, most of which were administrative errors in enrolling newborns.

Mr. KUCINICH. Thank you for your testimony and your complete testimony, as well.

Dr. Grover.

STATEMENT OF JANE GROVER

Dr. GROVER. Good afternoon, Chairman Kucinich and members of the subcommittee. My name is Dr. Jane Grover. I am very pleased to be here today representing the American Dental Association. In addition to being an ADA officer, I serve as the Dental Director for the Center for Family Health in Jackson, MI, a federally qualified health center. I also serve as a Medicaid reviewer for the Michigan Department of Community Health.

As the Dental Director in an FQHC and as an experienced private practitioner before that, I understand the problems with the dental component of the Medicaid program. In my opinion, we need to take three actions to properly care for the Medicaid population.

First, get many more dentists into the system, which is the primary focus of this hearing. Second, influence the geographic distribution of those dentists to make sure they can serve the Medicaid population in a timely fashion. Third, support other oral health initiatives that strengthen the oral health delivery system.

I address all of these points in my written testimony; however, in the interest of time I am going to focus primarily on the first point, attracting dentists to the Medicaid program.

A March 2008 study funded by the California Health Care Foundation confirmed what the ADA has been saying for some time: to improve dentists' participation in Medicaid, the States must improve fees, ease administrative burdens, and involve dentistry as an active partner. The Foundation's report examined six States where the number of participating dentists and patients seen in the Medicaid program rose significantly.

For purposes of my testimony, I will focus on the Michigan Healthy Kids Dental Program, which is essentially the same as the private sector Delta Dental Plan used by many people with coverage provided by their employers. Dentists are paid at a PPO rate, which might be less than the usual rate charged, but is still widely accepted.

The claims processing is identical to the private sector plan, except that beneficiaries have no co-pays and there is no annual maximum.

From the dentists' perspective, there is no difference between the Healthy Kids Dental Program and the widely accepted Delta Dental private plan. For patients, the stigma associated with being on Medicaid has been removed. Families cannot be differentiated into Medicaid and non-Medicaid groups. And the Healthy Kids Dental Plan has been a resounding success.

Dentists' participation shot from 25 percent to 80 percent 1 year after the program was introduced and now stands at 90 percent. The travel time to a dental office was cut in half, equaling that of the private sector Delta Dental Plans. The number of children with a dental home under the program far exceeds those with a dental home under the traditional Medicaid program in Michigan.

Unfortunately, about two-thirds of the Medicaid eligible children remain in the traditional Medicaid program in Michigan. More

needs to be done to bring all of the eligible children into the Healthy Kids Program.

We believe CMS can help by issuing guidance outlining how such collaborative activities have effectively worked in Michigan, Alabama, Tennessee, and other States. In addition, a letter from CMS to State Medicaid directors requiring them to report on steps they are taking to improve their dental Medicaid programs would also help.

The ADA also believes passing H.R. 2472, the Essential Oral Health Care Act, is important because the bill provides enhanced Federal matching funds if a State is willing to increase Medicaid fees, address administrative barriers, and reach out to the dental community.

Finally, regarding initiatives that strengthen the oral health delivery system, Mr. Chairman, we agree with the Congressional Research Service where, in its September 18, 2008, letter to this subcommittee, the agency identified barriers affecting the use of dental service among children. Those barriers include navigating government assistance programs, finding a dentist willing to accept Medicaid, locating a dentist close to home, transportation to a dental office, cultural and language barriers, lack of knowledge about the need for pediatric oral health care.

The ADA is seeking funding to conduct demonstration projects for a potential new dental team member, the community dental health coordinator, designed to address those barriers. We describe the CDHC fully in our written testimony.

Thank you, Mr. Chairman, for this opportunity to testify. I would be pleased to answer any questions.

[The prepared statement of Dr. Grover follows:]

STATEMENT FOR THE RECORD

Jane S. Grover, D.D.S., M.P.H.
First Vice President
American Dental Association
Before the

Domestic Policy Subcommittee
Oversight and Government Reform
“Necessary Reforms to Pediatric Dental Care under Medicaid”
Tuesday, September 23, 2008
2154 Rayburn HOB
10:00 a.m.

Executive Summary

The ADA applauds the subcommittee for its request for recommendations to increase the number of dentists providing services to children enrolled in Medicaid and we are pleased to offer our suggestions. It is important to note that over 90 percent of all practicing dentists are in the private sector. Safety net facilities that target underserved populations are, of course, very important but they employ relatively few dentists. For example, in fiscal year 2007, Health Centers receiving Section 330 funding employed about 2,107 (FTE) dentists. Even after significant growth in Health Centers in the past several years, that is still less than 2 percent of the total of 177,686 active dentists in the United States in 2005.

A March 2008 study funded by the California HealthCare Foundation confirmed what the ADA has been saying for some time – to improve dentists' participation in Medicaid, the States must do three things.

- improve the Medicaid fees;
- ease administrative burdens (make it look more like the private sector); and
- involve state dental societies and individual dentists as active partners in improving the program.

Many Medicaid fees are well below what it costs the dentist to provide the care. In addition, applications to become a Medicaid provider and other paperwork requirements (such as claims submissions) are often quite different from the paperwork necessary to participate in private

sector plans. All of this adds to the cost of providing care and might result in errors that trigger costly reviews. All of these serve as disincentives for private practitioners to participate.

The California HealthCare Foundation report examined six states (Tennessee, Washington, South Carolina, Virginia, Alabama, and Michigan) where the number of participating dentists and patients seen rose significantly. For purposes of this testimony, we discuss Michigan's "Healthy Kids Dental" (HKD) program in some detail because we have a good deal of information on the program (see attachments) and the program best illustrates how the Centers for Medicare and Medicaid Services (CMS) and Congress can encourage needed changes to the dental Medicaid program to increase the number of dentists providing services to children enrolled in Medicaid.

The Michigan Dental Association, the Michigan Department of Community Health, and Delta Dental of Michigan, Ohio and Indiana joined together in 2000 and worked with their state legislature and governor to develop and expand the HKD program.

Under the HKD program:

- dentists' participation shot up from 25 percent to 80 percent in one year and now stands at 90 percent;
- the time it took a Medicaid recipient to travel to the dentist's office was cut in half, equaling the travel time of patients covered by private sector Delta Dental plans; and
- the number of children with a "dental home" under the HKD program far exceeds those with a dental home under the traditional Medicaid program in Michigan.

By all measures, the HKD program is a resounding success and should be emulated by other States to the maximum extent feasible.

We believe there is a great deal that Congress and CMS can do to encourage other States to take measures to follow Michigan's lead. For example, Congress can fund grants to facilitate such collaborative activities and CMS can issue guidance outlining how such collaborative activities have effectively worked in Michigan, Alabama, Tennessee, and other States. Also, the agency could send a letter to State Medicaid Directors requiring the directors to report on measures they are going to take to improve their dental Medicaid programs.

The ADA, for its part, has encouraged State dental societies to reach out to other stakeholders in this fashion and have touted the success stories of Michigan and some of the other States. In addition, the ADA believes passing H.R. 2472, "The Essential Oral Health Care Act of 2007", is important because the bill provides enhanced federal matching funds if a state is willing to increase Medicaid fees, address administrative barriers and reach out to the dental community.

In addition to bringing many more dentists into the Medicaid system, more needs to be done to influence the distribution of those dentists to make sure they can serve the Medicaid population in a timely manner. This can be greatly facilitated by:

- incentives to get those dentists into underserved areas with student loan repayments and tax credits;
- grants to facilitate networking among local community officials and private sector dentists who want to practice in a rural underserved community as a means of helping the local communities help themselves.

Finally, there need to be initiatives that strengthen the oral health delivery system. To accomplish this goal, the ADA recommends the following:

- The ADA supports adjustments in the dental workforce, including Community Dental Health Coordinators. The CDHC will be a new allied dental provider who will enable the existing dental workforce to expand its reach into underserved communities. They will be competent in developing and implementing community-based oral health prevention and promotion programs; providing individual preventive services (such as fluoride and sealant applications); and performing temporization on dental cavities with materials designed to stop the cavity from getting larger (and alleviating pain) until a dentist can see the patient.
- The ADA also supports adequate funding of oral health infrastructure (including community-based water fluoridation and sealant programs), oral health education programs, and the efforts by Health Centers to provide care to all regardless of ability to pay.
- Finally, there is still a role for voluntary programs to deliver free or discounted oral health care to underserved children.

Testimony

Chairman Kucinich and members of the subcommittee, the American Dental Association (ADA), whose 155,000 members represent more than 72 percent of the dental profession, thanks you for holding this hearing and calling attention to the need for improving access to oral health care for America's children.

My name is Dr. Jane Grover, first vice president of the ADA and the Dental Director for the Center for Family Health (CFH). The CFH is a federally qualified health center (FQHC), dedicated to serving Jackson County, Michigan, and provides primary health care, including prenatal, pediatric, adolescent, adult, geriatric, behavioral health and dental care. The CFH serves all members of our community, regardless of their ability to pay. As director of a dental program in an FQHC and an experienced private practitioner before that, I understand the problems with the dental Medicaid program (both from the private and public practitioner perspective) and the challenges faced by underserved populations and oral health care providers. I am pleased to have this opportunity to appear before the subcommittee today to share some of these experiences.

Last year, the nation was shocked by the death of 12 year old Deamonte Driver—who lived only a short drive from here—from a brain infection apparently related to untreated dental disease. Clearly, the oral health care system failed this young man. All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us.

The impact of poor oral health can go far beyond the mouth. It is well documented that untreated oral health can lead to oral infections that can affect systemic health. New evidence of this is emerging all the time. Oral bacteria have also been associated with bacterial pneumonia in bed or chair-bound patients, and might also be passed from mother to child resulting in a higher prevalence of caries (tooth decay) in these children. Although it's not clear if treating an oral disease will improve specific health problems, we do know that oral health is important for overall health and vice versa.

Fundamental changes to the Medicaid program are long overdue to prevent the possibility of future tragedies like Deamonte and to ensure that all low-income children have the same access to oral health care services enjoyed by the majority of Americans.

Barriers to Accessing Oral Health Care Services

There are many barriers to providing every child from a low-income family in America with good oral health care services. Some of the barriers make it difficult to supply care (such as the geographic distribution of providers), some affect the demand for services, but all of them impact the ability of the underserved children to access dental services.

Supply Side Activities

According to the American Dental Education Association (ADEA) growing demand for dental care has resulted in the scheduled opening of eight new dental schools (in addition to the current 57 schools) in the next few years and beyond. This will include schools in Arizona, North

Carolina (in the eastern part of the state with a focus on rural access), Utah, Nevada, Texas, Wisconsin, Virginia, and New England. These new schools will significantly increase the number of dentists trained in the future and will go a long way towards addressing the needs of a growing population and providing care to underserved populations.

In addition to increasing the number of dentists in the nation the ADA recognizes that adjustments in the dental workforce are necessary to more effectively address the special needs of underserved communities, especially children. To help bring about these needed changes the ADA has created and is promoting the development of a new member of the dental team – the Community Dental Health Coordinator (CDHC). The CDHC will be a new allied dental provider who will enable the existing dental workforce to expand its reach into underserved communities.

These new oral health providers will be recruited from underserved dental areas and will share their communities' cultural values. CDHCs will be competent in developing and implementing community-based oral health prevention and promotion programs; providing individual preventive services (such as fluoride and sealant applications); and performing temporization of cavities with materials designed to stop the cavity from getting larger (and alleviating pain) until a dentist can see the patient.

In addition, they will learn skills necessary to reach out to underserved communities and make sure children previously unable to access the oral health delivery system are seen by a dentist.

The CDHC can be employed by Health Centers, the Indian Health Service, public health clinics or private practices.

If there had been a CDHC in the school that Deamonte Driver attended, we believe this tragedy could have been prevented. Through a routine exam, a CDHC could have spotted a simple cavity, filled the cavity with a temporary filling, and made arrangements for care by a dentist. If the CDHC had not come in contact with Deamonte until the cavity had become an abscess, the CDHC could have made immediate arrangements to get Deamonte emergency care. This committee heard testimony last year about how difficult it was for Mrs. Driver to find dentists who take Medicaid patients. The CDHC will be trained to help families enroll in the state Medicaid program, help them get transportation to appointments, and will follow up after treatment.

Congressional Action

Increasing the number of dentists nationally and expanding the dental team will definitely help to address dental access problems. But Congress needs to act to effectively reform oral health care under Medicaid. No matter who is providing the care, it is clear that the majority of the dental Medicaid programs are woefully under funded. Congress can take a positive step in addressing that problem by passing the "Essential Oral Health Care Act of 2007", H.R. 2472, which will provide enhanced federal matching funds to states willing to increase their fees and address administrative barriers and other impediments to ensuring provider participation.

The goal of H.R. 2472, which now has more than 55 co-sponsors, is to attract more private sector dentists into the Medicaid and SCHIP programs (over 90 percent of all practicing dentists are in the private sector), which is necessary if we are to truly address the problem. Under H.R. 2472, a State is offered a 25 percentage points increase (not to exceed 90 percent) of the Federal Medical Assistance Percentage (FMAP) with respect to expenditures for dental and oral health services for children if the State is willing to ensure the following:

1. Children enrolled in the State plan have access to oral health care services to the same extent as such services are available to the pediatric population of the State;
2. Payment for dental services for children under the State plan is made at levels consistent with the market-based rates;
3. No fewer than 35 percent of the practicing dentists (including a reasonable mix of general and pediatric dentists and oral and maxillofacial surgeons) in the State participate in the State plan and there is a reasonable distribution of dentists serving the covered population;
4. Administrative barriers are addressed, including improving eligibility verification, ensuring that any licensed dentist may participate in the publicly funded plan without having to participate in other plans, simplifying claims processing, assigning a single plan administrator for the dental program, and employing case managers to reduce the number of missed appointments; and
5. Educating caregivers regarding the need to seek dental services and addressing oral health literacy issues.

There currently are many federal dental programs that also work primarily at the state level to strengthen the dental safety nets. Each year, the ADA and other national dental organizations work to ensure adequate funding and administrative support for the Health Resources and Services Administration's Health Professions Education and Training Programs¹; HRSA's Maternal and Child Health Bureau (MCHB)²; the Centers for Disease Control and Prevention's

¹ Health professions education and training programs have a critical role in the recruitment and retention of minority and disadvantaged students and faculty. These programs are crucial if we are to address concerns with health disparities.

² Specifically, oral health projects in the Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), Title V, Special Projects of Regional and National Significance (SPRANS) account.

Division of Oral Health³; the National Institute of Dental and Craniofacial Research (NIDCR)⁴; the Ryan White HIV/AIDS Dental Reimbursement Program (Part F, Ryan White CARE Act)⁵; and most significantly, the Title VII general, pediatric and public health dentistry residency programs within HRSA.⁶ We call upon Congress to properly support these vital programs as part of our collective effort to fix the access problems for children from low-income families and other underserved.

Congress can also pass new laws that address mal-distribution problems of dentists that impede access to oral health care. The ADA has long supported incentives at the federal level to encourage private sector dentists to establish practices in underserved areas. For example, the Association advocates for tax credits as inducements to help bring dentists to underserved areas, as well as programs to help connect local elected officials and business people from underserved rural communities with dentists who want to practice in those communities. Local officials and business people willing to help underwrite a private dental practice in an underserved rural area by, for example, helping to defray the cost of setting up an office can be a very effective way of targeting resources to address a specific need and does not require an extensive, cumbersome

³ The Centers for Disease Control and Prevention's Division of Oral Health (DOH) supports state- and community-based programs to prevent oral disease, promote oral health nationwide and foster applied research to enhance oral disease prevention in community settings. The CDC works with states to establish public health research that provides valuable health information to assess the effectiveness of programs and target populations at greatest risk. In addition, through the DOH, states can receive funds to support prevention programs that aim to prevent tooth decay in high-risk groups, particularly poor children, and reduce oral health disparities.

⁴ NIDCR is the only Institute within the NIH that is committed to oral health research and training. Institute-sponsored research continues to link oral infection to such systemic diseases as diabetes, cardiovascular disease (heart attack and stroke) and adverse pregnancy outcomes (preterm birth and low birth weight). The Institute remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research.

⁵ The Ryan White HIV/AIDS Dental Reimbursement Program increases access to oral health services for people living with HIV/AIDS; ensures that dental and dental hygiene students and dental residents receive the most current training; and assist in defraying the rising non-reimbursed costs associated with providing such care by dental education institutions.

⁶ Title VII dental residency programs are instrumental in training dentists who work in underserved communities and treat Medicaid, SCHIP or other underserved populations, particularly those with special needs.

federal government program. The federal government can be helpful in facilitating such arrangements by providing grants to set up networks that match interested local communities and dentists.

The ADA also works with and supports our colleagues who practice in Health Centers, which receive Section 330 funding in exchange for providing care to all regardless of ability to pay. We have an excellent working relationship with the National Association of Community Health Centers (NACHC) and encourage our private sector members to work cooperatively with the centers in their communities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers, thereby providing the centers with another option to efficiently provide dental services to Health Center patients when and where those services are needed. Last year's SCHIP legislation contained a provision that clarified such arrangements are legal.

Rep. Elijah Cummings, a member of this Committee, has also introduced a bill which the ADA supports and believes could improve pediatric dental care in Health Centers. H.R. 2371, "Deamonte's Law", would provide increased funding to allow the centers to hire more pediatric dentists. It would also increase the number of pediatric dental training programs in the country.

Rep. Cummings also added a provision to the SCHIP legislation last year that called for ensuring that all new mothers that qualify for Medicaid or SCHIP receive educational information on pediatric oral health care shortly after giving birth. The ADA strongly supports this initiative and hopes that Congress can include it in the next SCHIP bill.

Non-governmental Activities

Dentists understand their ethical and professional responsibilities. In the absence of effective public health financing programs, many state dental societies joined with other community partners to sponsor voluntary programs to deliver free or discounted oral health care to underserved children. According to the ADA's *2000 Survey of Current Issues in Dentistry*, 74.3 percent of private practice dentists provided services free of charge or at a reduced rate to one or more groups (e.g., homebound, handicapped, low income). A total national estimate of the value of this care was \$1.25 billion, or \$8,234 per dentist. In 2003, the ADA launched an annual national program called "Give Kids A Smile". The program reaches out to underserved communities, providing a day of free oral health care services. "Give Kids A Smile" helps educate the public and state and local policymakers about the importance of oral health care while providing needed and overdue care to large numbers of underserved children. The ADA's sixth annual Give Kids A Smile event on February 1, 2008, was again highly successful. More than 47,000 dental team members registered to participate. Nationwide, 1,800 programs were held. This program treated about 500,000 children. The estimated value of that care was over \$29.8 million. Poor children shouldn't have to depend on charity for basic dental care. These efforts are important but are no substitute for fixing the Medicaid program.

Demand Side Activities

In the testimony above, we commented on the SCHIP provision promoted by Rep. Cummings to provide new mothers with oral health information. University researchers seeking to identify the barriers to oral health care faced by caregivers for low-income individuals concluded that efforts

need to be made to educate caregivers about the importance of oral health to overall health.⁷

The ADA and other professional dental organizations agree that early intervention is very important in assuring that a child has good oral health. Accordingly, the ADA recommends that children see a dentist for the first time within 6 months of the appearance of the first tooth and no later than the child's first birthday.⁸ The American Academy of Pediatric Dentistry also recommends that all children should visit a dentist in their first year of life and every six months thereafter, or as indicated by the individual child's risk status or susceptibility to disease.⁹

The ADA also has a number of initiatives it is undertaking to address oral health literacy issues. They include: implementing an advocacy strategy to increase the number of school districts requiring oral health education for K-12 students; encouraging the development of oral health literacy continuing education programs to train dentists and allied dental team members to communicate effectively with patients with limited literacy skills; and developing guidelines for the creation of educational products to meet the needs of patients with limited literacy skills, including involving targeted audiences to help develop materials.

Challenges Associated with the Medicaid Program

To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid because over 90 percent of all

⁷ S.E. Kelly; C.J. Binkley; W.P. Neace; B.S. Gale, "Barriers to Care-Seeking for Children's Oral Health Among Low-Income Caregivers," *American Journal of Public Health*, Aug 2005; 95, 8; Alumni – Research Library, pg. 1345.

⁸ American Dental Association, ADA statement on early childhood caries, 2000. Available from: www.ada.org/prof/resources/positions/statements/caries.asp

⁹ American Academy of Pediatric Dentistry, Guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Available from: www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

practicing dentists are in the private sector (totaling over 162,000). Safety net facilities that target underserved populations are, of course, very important but they employ relatively few dentists. Efforts to expand care *only* through safety net facilities will not fix the access problem. For example, in fiscal year 2007, Health Centers receiving Section 330 funding employed about 2,107 (FTE) dentists.¹⁰ Even after significant growth in Health Centers in the past several years, that is still less than 2 percent of the total of 177,686 active dentists in the United States in 2005.¹¹

Seventy-five percent of Medicaid enrollees are children and their parents and about half of the program's 60 million 2006 enrollees are poor children, making it the federal government's largest health care program in terms of enrollment.¹² At the same time, according to the Congressional Budget Office (CBO), many eligible people do not enroll in the program and there have been estimates that about 33 percent of the 10 million children identified as uninsured are eligible for Medicaid.¹³ So, experts estimate that more than 30 million American children meet Medicaid eligibility requirements.

There are a number of factors that work against bringing more private sector dentists into the Medicaid program – but they can be overcome if we work together. As CBO points out, analyses of Medicaid's reimbursement rates have found them to be lower than Medicare or private insurance rates.¹⁴ This was also discussed in a General Accountability Office study,

¹⁰ DHHS, HRSA, BPHC, 2007 Uniform Data System.

¹¹ American Dental Association, Survey Center.

¹² Congressional Budget Office, Medicaid Spending Growth and Options for Controlling Costs, Statement before the Special Committee on Aging, July 13, 2006, pp. 1-3.

¹³ T.M. Selden, J.L. Hudson, and J.S. Ban thin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, vol. 23, no. 5 (September-October 2004), pp. 39-50.

¹⁴ CBO, *Ibid.* at p. 4.

which recognized a number of administrative barriers.¹⁵ More recently, a July 2008 report funded by the Kaiser Commission on dental Medicaid and SCHIP stated that Medicaid rates often do not cover dentists' costs of providing care and that overhead costs (60 cents of every dollar earned) exceed those of most physicians.¹⁶

In short, the vast majority of the dental Medicaid programs in the United States are woefully under funded and the reimbursement rates simply cannot attract enough dentists as they do not cover overhead costs. Where these programs have been enhanced, the evidence is clear that dentist participation increases significantly. In addition, high student debt pressures young dentists to go into the private sector and makes it fiscally less feasible to take public health or clinic positions. Significantly, the American Dental Education Association reported that indebtedness for dental school graduates averaged \$172,627 for 2007, with public school graduates averaging \$148,777 and private/State-related school graduates averaging \$206,956. This level of debt puts a great deal of pressure on young dentists to set up private practices in relatively affluent areas to the exclusion of underserved areas.

Solutions at the State Level

In a March 2008 study funded by the California HealthCare Foundation¹⁷ the authors concluded that to improve the dental Medicaid program fee increases are necessary, but there must also be an easing of administrative processes and an effort to involve state dental societies and individual

¹⁵ General Accounting Office, "Oral Health ... Factors Contributing to Low Use of Dental Services by Low-Income Populations," September 2000. p.4.

¹⁶ National Academy for State Health Policy, The Kaiser Commission on Medicaid and the Uninsured, "Filling an Urgent Need: Improving Children's Access to Dental Care in Medicaid and SCHIP", July 2008.

¹⁷ California HealthCare Foundation, "Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?" March 2008.

dentists as active partners in improving the program. The report examined six states (Tennessee, Washington, South Carolina, Virginia, Alabama, and Michigan) where the number of participating dentists and patients seen rose significantly. The factors that contributed to the success experienced by those states were discussed in the context of the California program, where patient utilization and provider participation are low.

Providing details on a very successful dental Medicaid program -- a September 2008 study of the first six years of Michigan's "Healthy Kids Dental" (HKD) Medicaid program¹⁸ concludes that access to dental care continues to improve; an increasing proportion of children receive dental care each year from local providers close to home; and many of the children in the program appear to have a dental home and are entering regular recall patterns. The HKD program is administered by Delta Dental of Michigan, dentists are paid usual delta PPO fees, the child may select any participating dentist, the standard Delta claims administration is used, and there are no co-payments or annual maximums. In other words, it looks just like many of the private sector plans accepted by the dentists in the counties covered by the HKD program.

According to Dr. Eklund¹⁹, introduction of the HKD program precipitated a dramatic rise in the number of dentists participating in the Medicaid program. Before HKD, in 2000, fewer than 25 percent of the dentists participated in Medicaid within the counties that were later covered by the HKD program. Within one year of the introduction of HKD in 2001, that number rose to over 80 percent participation and by 2005 dental participation was over 90 percent within the same

¹⁸ S.A. Eklund, Michigan's Medicaid "Healthy Kids Dental" Program, University of Michigan School of Public Health, September 4, 2008 (see attachments).

¹⁹ Stephen A. Eklund, D.D.S., M.H.S.A., DrPH, Professor Emeritus, University of Michigan School of Public Health, Consultant to Delta Dental of Michigan, Ohio and Indiana.

counties that just four years earlier had been below 25 percent. As a consequence, according to Dr. Eklund, the amount of time it took a Medicaid recipient to travel to the dentist's office was cut in half, equaling the travel time of patients covered by private sector Delta Dental plans. The current HKD program was expanded to 61 of Michigan's 83 counties, effective July 1, 2008; however, the program still covers only about 33 percent of Medicaid eligible children because the traditional Medicaid program remains in place in some of the larger communities.

A comparison of the traditional Medicaid program, the HKD program, and the private sector Delta plans clearly shows that dramatic positive effects on access have taken place for the children under the HKD program. For example, the HEDIS²⁰ measure of annual dental visits for the traditional program (2004) was just over 36 percent for children ages 2 to 21, while the HKD (2004) HEDIS measure was over 52 percent, rising to over 56 percent by 2007, which is much closer to the well established Delta plans, which registered a 71 percent HEDIS measure for its largely middle class population. Also, implementation of the HKD program has greatly increased the number of children with a "dental home" (defined as two or more preventive visits with the same dentist in a year). In 2007, the percent of HKD children (enrolled in the program for 12 months) with a dental home was 29.9, which compares favorably to the 36.5 percent of Delta children with a dental home when one considers the Delta plans have been around for many years and the populations served by those plans often have long standing relationships with their dentists.

²⁰ The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service, according to the National Committee for Quality Assurance.

Between October 2002 and October 2006, the number of dentists participating in the TennCare dental program grew by 112 percent and in rural counties by 118 percent.²¹ This growth occurred after the dental program was “carved out” of the Medicaid medical program in 2002, whereby the dental care was administered by its own benefits manager and had its own funding stream, comprising 2 percent of the entire TennCare budget. The carve out facilitated the development of a good working relationship with the Tennessee Dental Association and other stakeholders, resulting in a streamlined dental administrative process, among other improvements. Four other states use a similar dental carve out system – California, Illinois, Massachusetts (in progress), and Virginia. Finally, the Alabama program (Smile Alabama!) has also significantly improved dentist participation. State officials note the increase in reimbursement rates and its outreach to dentists as significant contributing factors in growing that program.²²

To be clear, the Association is not suggesting that the programs discussed above are the only ways to begin to address the oral health access problems facing low-income children – or even the best ways in all cases. We are simply suggesting that while the problems are considerable, they are not insurmountable if all parties work together.

In fact, the success of the “Healthy Kids Dental” program in Michigan illustrates what can be done when stakeholders work cooperatively toward a common goal. The Michigan Dental Association, the Michigan Department of Community Health, and Delta Dental of Michigan, Ohio and Indiana joined together and worked with their state legislature and governor to develop and expand the HKD program. We believe there is a great deal that Congress and the Centers

²¹ J. Gillcrist, “TennCare Dental Program: Before and After the Carve Out”

²² Smile Alabama! “Alabama Medicaid’s Dental Outreach Initiative.”

for Medicare and Medicaid Services (CMS) can do to encourage other states to take similar measures to improve their dental Medicaid programs through grants and other means.

Conclusion

All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us. Fundamental changes to the Medicaid program are long overdue to ensure that low-income children have the same access to oral health care services enjoyed by the majority of Americans. While we have made progress toward reducing the morbidity of oral disease, significant and persistent disparities continue to adversely affect underserved populations. The problems are numerous and complex, but they are not insurmountable. For too long, dental disease has been the "silent epidemic."

Mr. Chairman, our nation's most vulnerable citizens deserve better care than we have so far provided. The ADA stands ready to do its part, and we call upon our many friends in Congress to work with us to ensure that every child can face his or her future with a smile.

Michigan's Medicaid "Healthy Kids Dental" program

Stephen A. Eklund, DDS, MHSA, DrPH
Professor emeritus, University of Michigan School of
Public Health

Consultant to Delta Dental of Michigan, Ohio and
Indiana

September 4, 2008

1

Healthy Kids Dental Program

- Administered by the Delta Dental of Michigan
- Dentists paid usual Delta fees, according to coverage type
- Child may use any participating provider
- Program eligibility based on child's county of residence, not location of the dentist
- Standard claims administration (same as for all other Delta patients)
- 100% payment (no patient co-payments)
- No annual maximum

2

Michigan Healthy Kids Dental

- Began on May 1, 2000 in 22 of Michigan's 83 counties
- Expanded to 37 counties on October 1, 2000
- Expanded to 59 counties on May 1, 2006
- Expanded to 61 counties on July 1, 2008

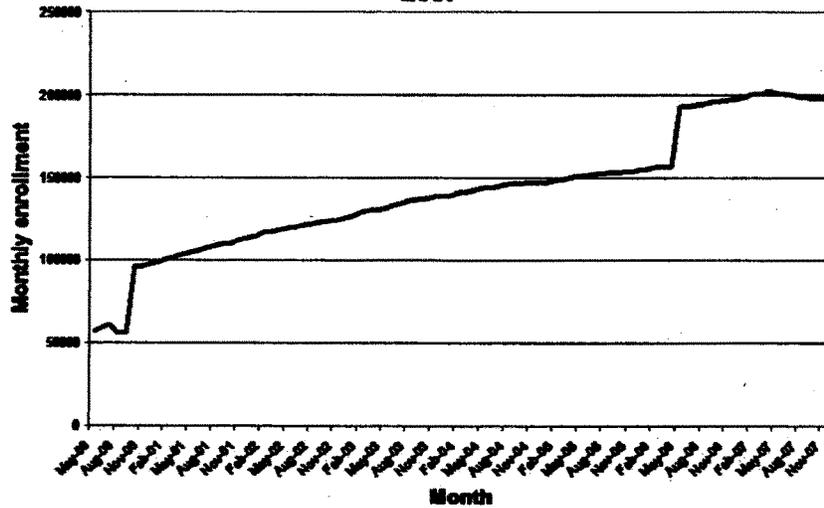
3

Michigan Healthy Kids Dental

- Initially 18 counties conventional fee for service, 4 counties PPO.
- Became 33 conventional fee for service and 4 PPO with first expansion.
- Four counties were changed to PPO on January 1, 2004, for a total of 8.
- All counties switched to the PPO fee structure on January 1, 2006 but dentists not required to become Delta PPO providers.

4

HKD enrollment by month, May 2000 through December 2007



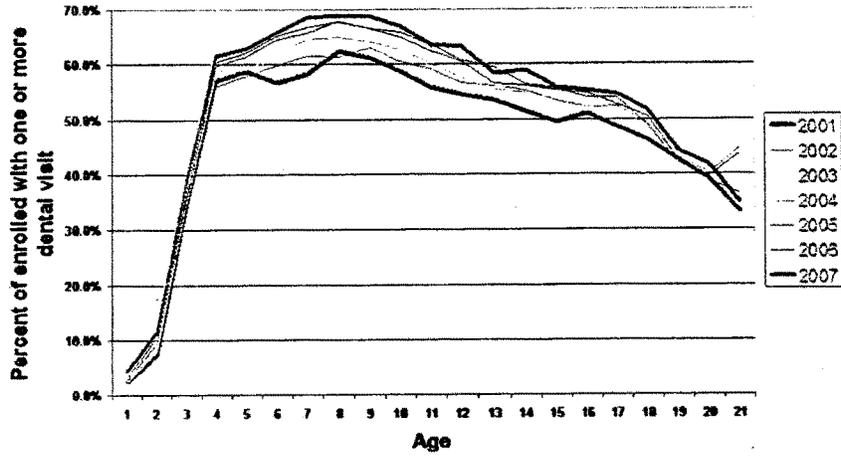
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Enrollment and Access

Year	Any enrollment		12 month enrollment		1 to 11 month	
	Enrolled	Users (%)	Enrolled	Users	Enrolled	Users
2001	162,878	48,714 (29.9)	55,538	27,226 (49.0)	107,142	21,448 (20.0)
2002	178,519	57,032 (31.9)	66,725	33,843 (50.4)	111,794	23,389 (20.9)
2003	192,327	63,856 (33.2)	76,673	39,437 (51.4)	115,654	24,419 (21.1)
2004	204,664	68,058 (33.2)	84,524	43,443 (51.4)	120,140	24,615 (20.5)
2005	213,447	74,027 (34.7)	90,003	47,831 (51.4)	123,474	26,196 (21.2)
2006	266,593	93,148 (35.0)	94,654	50,906 (53.1)	171,939	42,242 (24.6)
2007	273,850	101,637 (37.1)	120,974	66,718 (55.2)	152,876	34,919 (22.8)

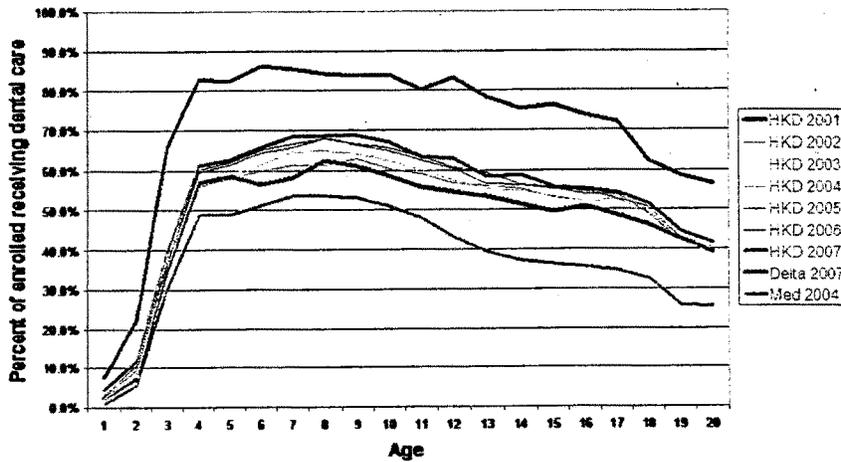
6

Michigan Healthy Kids Dental utilization of dental care, 12 month enrollment in calendar year, by age



7

HKD, Medicaid, and Delta private utilization of dental care, 12 month enrollment in calendar year, by age



8

HEDIS Annual Dental Visit for HKD

Age	2001	2002	2003	2004	2005	2006	2007
2 to 3	20.4%	21.1%	21.7%	21.9%	22.4%	23.2%	25.3%
4 to 6	56.4%	57.2%	58.8%	58.5%	61.0%	61.8%	62.6%
7 to 10	59.5%	60.9%	62.9%	63.2%	65.5%	66.0%	67.5%
11 to 14	53.5%	56.2%	56.4%	56.5%	58.0%	59.4%	60.3%
15 to 18	48.9%	51.6%	51.8%	51.1%	52.9%	52.7%	53.8%
19 to 21	40.1%	42.6%	43.5%	40.3%	40.4%	40.8%	43.0%
2 to 21	50.0%	51.6%	52.5%	52.4%	54.2%	54.8%	56.2%

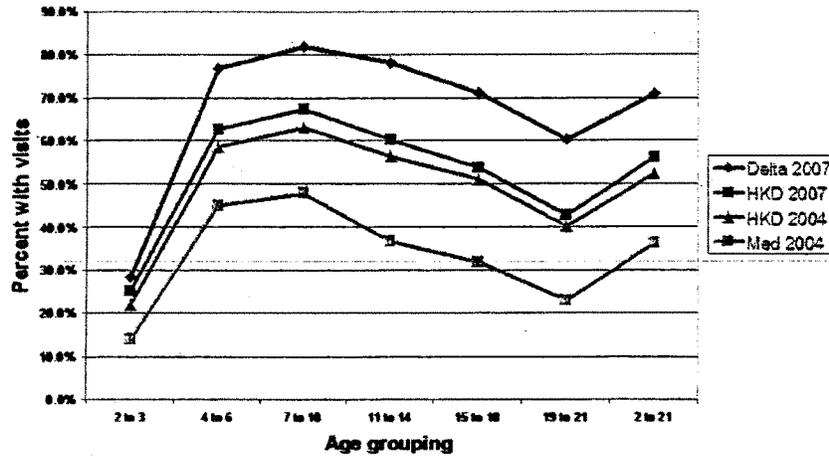
9

HEDIS Annual Dental Visit for Delta, HKD, and Medicaid

Age	Delta 2007	HKD 2007	HKD2004	Med 2004
2 to 3	28.5	25.3	21.9	14.0
4 to 6	77.0	62.6	58.5	45.0
7 to 10	82.0	67.5	63.2	48.0
11 to 14	78.3	60.3	56.5	36.7
15 to 18	71.2	53.8	51.1	31.9
19 to 21	60.3	43.0	40.3	23.0
2 to 21	71.0	56.2	52.4	36.3

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HEDIS annual visit for HKD, Medicaid, and Delta commercial



Participating dentists

Number of dentists and number of children receiving treatment

Year	Dentists	Children treated (Children/dentist)	Child-dentist combinations (Children per dentist)
2001	1544	48,714 (31.6)	56,971 (36.7)
2002	1624	57,032 (35.1)	66,354 (40.9)
2003	1715	63,856 (37.2)	74,307 (43.3)
2004	1773	68,058 (38.4)	79,599 (44.9)
2005	1926	74,027 (38.4)	88,951 (46.2)
2006	2255	93,148 (41.3)	109,440 (48.5)
2007	2243	101,637 (45.3)	122,841 (54.8)

Dental Home

Two or more preventive visits with the same dentist in the year

Year	Number of HKD children with two or more preventive visits per year	Percent of HKD children with two or more preventive visits per year	Percent of Delta children with two or more preventive visits per year	Percent of HKD 12-month enrolled children with two or more preventive visits per year
2001	9,202	19.9	38.4	26.9
2002	12,138	22.8	38.0	29.7
2003	14,729	24.4	38.3	31.3
2004	16,365	25.4	38.7	32.0
2005	17,788	24.8	37.2	30.9
2006	20,099	22.8	35.9	31.6
2007	23,909	24.4	36.5	29.9

Procedures per user

Year	D&P	Resto	Endo	Perio	Pros	OSurg	Adj	Total
2001	4.24	1.51	0.09	0.01	0.00	0.31	0.03	6.19
2002	4.31	1.52	0.10	0.01	0.00	0.32	0.03	6.29
2003	4.41	1.50	0.10	0.01	0.00	0.31	0.03	6.36
2004	4.44	1.46	0.10	0.00	0.00	0.31	0.04	6.34
2005	4.53	1.45	0.09	0.00	0.00	0.32	0.04	6.45
2006	4.42	1.33	0.09	0.01	0.00	0.21	0.02	6.08
2007	4.58	1.35	0.09	0.01	0.00	0.22	0.02	6.27

Percent of total cost by major procedure code groupings

Year	D&P	Resto	Endo	Perio	Pros	OSurg	Adj
2001	41.7	38.5	7.0	0.4	0.3	10.8	1.3
2002	40.5	39.3	7.3	0.4	0.4	10.9	1.3
2003	41.4	38.8	7.2	0.3	0.3	10.8	1.3
2004	42.8	36.6	7.3	0.1	0.3	11.3	1.5
2005	42.2	36.1	7.1	0.1	0.3	12.4	1.8
2006	47.4	38.1	6.8	0.2	0.2	6.5	0.8
2007	47.4	37.6	6.8	0.3	0.3	6.8	0.9

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Paid* per user

Year	D&P	Resto	Endo	Perio	Pros	OSurg	Adj	Total
2001	143.98	133.15	24.31	1.48	1.21	37.20	4.37	345.68
2002	151.85	147.42	27.25	1.56	1.38	40.83	4.79	375.08
2003	160.63	150.58	27.99	1.06	1.00	41.92	5.07	388.26
2004	160.50	137.50	27.46	0.40	1.14	42.41	5.78	375.19
2005	164.71	140.99	27.52	0.47	1.06	48.50	7.08	390.32
2006	139.08	111.85	20.11	0.70	0.61	19.04	2.33	293.71
2007	141.74	112.35	20.30	0.79	0.75	20.24	2.77	298.94

*All dollar amounts presented are adjusted for inflation using the 2007 All Item Consumer Price Index (CPI), and reported in 2007 dollars.

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SUMMARY

- Access to dental care has continued to improve under HKD.
- The change to PPO fee levels in 2006 does not appear to have slowed the increase in access to care.
- More children and an increasing proportion of children receiving dental services each year.
- The number of dentists providing care continues to increase, leveling off on 2007.

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SUMMARY - continued

- The number of children treated per dentist continues to increase.
- Children are receiving services from local providers close to home.
- Many *HKD* children appear to have a dental home and to be entering regular recall patterns.

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Mr. KUCINICH. Thank you very much.
Dr. Crall, you may proceed. Thank you.

STATEMENT OF JIM CRALL

Dr. CRALL. Thank you, Mr. Chairman. And I thank members of the subcommittee for the opportunity to participate in this hearing.

My comments today largely focus on the impact of Medicaid reimbursement rate increases on dentist participation and children's utilization of dental services in Medicaid, and the benefits of no-risk contractual arrangements that separate or carve out Medicaid dental benefits from global Medicaid managed care arrangements.

Access to an ongoing source of comprehensive dental care is a critical component for maintaining good oral health in children. Access to a dental home or regular source of dental care is especially important for children who are at elevated risk for tooth decay, predominantly children in low-income families and children with special health care needs, children typically covered by Medicaid.

National surveys showing an increase in tooth decay in young children, what we now call early childhood caries, combined with the already large and growing numbers of children on Medicaid underscore the need for engaging substantial numbers of dentists as Medicaid providers across the United States. However, chronically low reimbursement to dentists for services rendered has been acknowledged by several private and governmental reports to be a major, if not the greatest, barrier to dentist participation in Medicaid.

Access to dental services for children covered by Medicaid is a significant and chronic problem. Studies conducted by the U.S. Department of Health and Human Services in 1996 reported that, A, relatively few children covered by Medicaid received recommended dental services; and, B, inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid.

The GAO's April 2000 Report to Congress indicated that the level of Medicaid dental reimbursement in 1999 nationally and in most States was about equal to or less than the 10th percentile of respective fees; that is, at least 90 percent of dentists charged more, and usually substantially more, than the Medicaid fee.

A subsequent assessment conducted in 2004 by myself and Dr. Don Schneider, former Chief Dental Officer at CMS, found that in 41 States the majority of dental Medicaid reimbursement rates for common children's dental procedures remained below the 10th percentile, and frequently were below even the first percentile of dentists' fees, meaning that the Medicaid rates were lower, and often substantially lower, than the fees charged by any dentist in the respective States.

Beginning in the 1990's, following a series of Oral Health Policy Academies organized by the National Governors Association, several States moved to increase Medicaid reimbursement levels to considerably higher levels consistent with the market-base approach advanced in the NGO Oral Health Policy Academy. As shown on the table on this slide, subsequent evaluations suggest that, similar to the findings by the GAO, Medicaid payments that approximate prevailing private sector market fees do contribute to increased participation by dentists in Medicaid.

Other States, including Virginia, Texas, and Connecticut, also have taken steps to raise their Medicaid dental reimbursement rates to what are considered reasonable, market-based rates. Unfortunately, as in the case of Connecticut and Texas, these changes often follow years of protracted litigation in Federal courts.

The table on the next slide provides a comparison of Texas Medicaid payment rates for selected procedures and fees charged by dentists within the State of Texas. This chart basically illustrates comparisons that are typical of many other States. You can see that in 2004, for example, for a periodic oral examination, or Code D-0120, that the Texas payment rate of \$14.72 was roughly half of what the 50th percentile or average rate fee that dentists charge.

More strikingly, if you look at the far right column on this table you will see that for 11 of the procedures that we normally monitor to try to assess adequacy of payment levels in Medicaid, that the Texas rates, as is true in many, many other States, was below the first percentile, or below what any dentist considers a reasonable charge for those services.

In September 2007, however, following a settlement in the Federal court case of *Frew v. Hawkins*, Texas EPSTD dental Medicaid reimbursement rates for 35 common procedures were raised by 100 percent, effectively to the 50th percentile of Texas dentists' fees. This action followed more than a decade of essentially stagnant dental Medicaid rates in the face of steady modest increases in the cost of dental care, typically between 4 and 5 percent per year.

Significant increases also were provided for approximately 20 additional relatively common dental procedures.

Information obtained from individuals involved in the *Frew* case indicates that following Medicaid reimbursement rate increases in Texas the State has issued approximately 500 new Texas Medicaid dental provider numbers. The actual number of new dentists in the program is not clear at this time because in Texas a dentist may have more than one provider number if they operate in multiple locations.

The entire section of the document that the AAPD submitted to the Health Care Financing Administration, now CMS, on program financing and payments, Section C in the submitted table of contents, was deleted from the published version of the Guide to Children's Dental Care in Medicaid. Topics addressed within that section are delineated within my written testimony.

Additional information provided in the Guide showed that roughly \$14 to \$17 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 to \$20 PMPM.

A subsequent actuarial analysis commissioned by the American Academy of Pediatric Dentistry in 2004 generally affirmed those findings; however, available information suggests that many States allocate only a small fraction of the financial resources suggested by these actuarial studies, oftentimes on the order of \$5 to \$7 per beneficiary per month.

Now, shifting to the impact of Medicaid rates on increases in children's use of dental services, perhaps more directly to the point, the table on the next slide shows data from CMS 416 annual reports illustrating significant increases in utilization of dental services by children covered by Medicaid in five States following significant reimbursement rate increases.

The increased use of dental services demonstrated in this slide also constitutes a significant positive impact of Medicaid dental reimbursement rate increases.

The rate increases, which have been implemented in these and a handful of other States, were not done in isolation; they are generally part of a broader combination of actions designed to address issues which have been identified as chronic barriers to dentist participation and access to dental care in Medicaid.

Although addressing these other issues is viewed as an important element of comprehensive dental Medicaid program reform, increasing Medicaid rates to reasonable, market-based levels is critical to obtaining adequate levels of dentist participation in Medicaid.

Finally, commenting on the topic of the advantages of no-risk contractual arrangements or carve-outs for dental Medicaid benefits, in addition to the essential step of raising Medicaid dental reimbursement rates to reasonable, market-based levels, many States also have taken steps to implement no-risk or administrative services only, ASO, contracts that separate or carve out dental Medicaid benefits from global Medicaid managed care arrangements. Examples include Michigan's Healthy Kids Dental Program and Medicaid dental programs in Connecticut, Maryland, Tennessee, and Virginia.

Such arrangements eliminate the need for subcontracting between global Medicaid managed care organizations, which often are not in the business of providing dental benefits, and dental benefits managers. This change not only helps to simplify program administration and reduce confusion among dentals and Medicaid beneficiaries, alike; the no-risk aspect also helps to eliminate the inherent incentive in risk-based contractual arrangements for managed care organizations and/or dental benefit managers to reduce payments to dentists in order to enhance the intermediary's profits.

In addition to simplifying the administration of Medicaid dental benefits, these arrangements allow States to retain greater control in establishing reimbursement rates while affording reasonable profits for dental benefits managers.

Additional advantages of the single vendor approach, as was mentioned for Virginia, from the dentists' perspective include more streamlined enrollment procedures, because dentists do not need to fill out multiple enrollment forms and undergo credentialing by multiple dental benefits management organizations, and less confusion about program policies governing allowable services and billing processes, which often results from having multiple intermediaries.

Moreover, contracting with a single dental Medicaid intermediary or a single vendor simplifies the contracting process, improves the ease of program monitoring, and has the potential for

better contract enforcement on the part of State Medicaid programs.

So, in summary, several States have taken significant steps to increase dentist participation and access to dental services in their Medicaid ETSDP programs over the past decade. Successful efforts generally have involved the necessary step of raising Medicaid dental reimbursement rates to reasonable, market-based levels, combined with additional steps to make Medicaid dental program administration more dentist friendly. Streamlining provider enrollment and implementation of no-risk, contractual arrangements that separate or carve-out Medicaid dental benefits contracting from global Medicaid managed care arrangements have been prominent parts of these strategies. In my opinion, promoting the adoption of these strategies by other States would help to substantially improve children's access to dental care and Medicaid.

Overall, basically we need to give credit for the States that have demonstrated leadership in reforming their dental Medicaid programs for children; however, clearly more systematic efforts are necessary, and additional congressional and regulatory assistance, whether it be in the form of an increase in the FMAP rates, loan repayment or loan forgiveness for dental school faculty and new dentists entering practice, or demonstration programs are needed and would be welcome.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Crall follows:]

**WRITTEN
TESTIMONY
OF**

James J. Crall, DDS, ScD

Domestic Policy Subcommittee
Oversight and Government Reform Committee
Tuesday, September 23, 2008
2154 Rayburn HOB
10:00 a.m.

“Necessary Reforms to Pediatric Dental Care under Medicaid”

I, James J. Crall, D.D.S., Sc.D., hereby submit the following as written testimony pursuant to the Subcommittee’s request for my views on policy reforms that have been proven to improve access to, and utilization of, pediatric dental care in Medicaid. This testimony concerns the hearing to be held on Tuesday, September 23, 2008 at 10:00 a.m. in Room 2154 of the Rayburn House Office Building. My comments largely focus on (1) the impact of Medicaid reimbursement rate increases on dentists’ participation and children’s utilization of dental services in Medicaid and (2) the benefits of no-risk contractual arrangements that separate or ‘carve out’ Medicaid dental benefits from global Medicaid managed care arrangements. I sincerely appreciate the opportunity to participate in this hearing.

1. Impact of Medicaid Reimbursement Rate Increases

a. Impact on Dentists’ Participation in Medicaid

Access to an ongoing source of dental care is a critical component for maintaining good oral health in children. Access to a ‘dental home’ or regular source of dental care is especially important for children who are at elevated risk for tooth decay (dental caries), predominantly children in low-income families and children with special health care needs, who generally are covered by Medicaid. National surveys showing an increase in tooth decay in young children (what we now refer to as Early Childhood Caries or ECC) combined with the already large and growing numbers of children on Medicaid (nearly 30 million or 1-in-3 American children) underscore the need for engaging substantial numbers of dentists as Medicaid providers across the U.S. However, chronically low reimbursement to dentists for services rendered has been acknowledged by several private and governmental reports to be a major, if not the greatest, barrier to dentists’ participation in Medicaid.

Relationship between Reimbursement and Access to Dental Services for Children in Medicaid

Access to dental services for children covered by Medicaid is a significant and chronic problem. Studies conducted by the U.S. Department of Health and Human Services¹ report that (a) relatively

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.

few children covered by Medicaid receive recommended dental services and (b) inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid. Reports issued by the U.S. General Accounting Office^{2,3} (GAO) to Congress in 2000 noted that Medicaid payment rates often were well below dentists' prevailing fees and that "as expected, payment rates that are closer to dentists' full charges appear to result in some improvement in service use."

The GAO's April 2000 Report to Congress 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 10th percentile of respective fees – i.e., at least 90 percent of dentists charged more, and usually substantially more, than the Medicaid fee. A subsequent assessment conducted in 2004 by myself and Dr. Don Schneider (former Chief Dental Officer at CMS) found that in 41 states, the majority of Medicaid dental reimbursement rates for common children's dental procedures remained below the 10th percentile and frequently were below even the 1st percentile of dentists' fees – meaning that the Medicaid rates were lower (and often substantially lower) than the fees charged by any dentist in the respective states.

Impact of Efforts by Some States to Establish Market-based Medicaid Reimbursement Rates

Beginning in the late 1990s, following a series of Oral Health Policy Academies organized by the National Governors Association, several states moved to increase Medicaid reimbursement levels to considerably higher levels consistent with the market-based approach advanced during the NGA Policy Academies. As shown in the table below, subsequent evaluations suggest that (similar to findings by the GAO) Medicaid payments that approximate prevailing private sector market fees do contribute to increased participation by dentists in Medicaid.

STATE	Market Benchmarks for Adjustments to Medicaid Rates	Changes in Dentists' Medicaid Participation	Intervals After Rate Increases (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 of dentists' fees	+58%	54
Michigan Healthy Kids Dental	100% of Delta Dental Premier (16 counties)	+300%	12
South Carolina	75th percentile of dentists' fees	+73% +88%	36 42
Tennessee	75th percentile of dentists' fees	+81%	20

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.

Other states, including Virginia, Texas and Connecticut also have taken steps to raise their Medicaid dental reimbursement rates to what are considered reasonable market-based rates. Unfortunately, as in the case of Connecticut and Texas, these changes often follow years of protracted litigation in federal courts. The table below provides a comparison of Texas Medicaid payment rates for selected procedures and fees charged by dentists within the State of Texas and within the West South Central (WSC) Region comprised of AR, LA, OK & TX. Details of the data elements are provided below.

TX Medicaid Payment Rates for Selected Procedures			Comparisons with Dentists' Claims for Insured Patients in the ADA West South Central (WSC) Region and in the State of Texas			
CDT4 Procedure Code	Procedure Description	TX Medicaid Payment Rate	WSC Region 50th Percentile	TX State 50th Percentile	TX State 75th Percentile	State Percentile Corresponding to TX Medicaid Payment Rate
Diagnostic						
D0120	Periodic Oral Exam	\$14.72	\$27.00	\$28.00	\$32.00	< 1st
D0150	Comprehensive Oral Exam	\$18.02	\$40.00	\$40.00	\$49.00	< 1st
D0210	Complete X-rays, with Bitewings	\$36.04	\$67.00	\$65.00	\$81.00	2nd
D0272	Bitewing X-rays - 2 Films	\$11.93	\$25.00	\$25.00	\$29.00	< 1st
D0330	Panoramic X-ray Film	\$32.54	\$65.00	\$65.00	\$75.00	1st
Preventive						
D1120	Prophylaxis (cleaning)	\$13.75	\$40.00	\$42.00	\$47.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	\$7.50	\$19.00	\$19.00	\$22.00	< 1st
D1351	Dental Sealant	\$18.55	\$33.00	\$35.00	\$39.00	< 1st
Restorative						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	\$43.73	\$88.00	\$91.00	\$107.50	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	\$52.57	\$110.00	\$119.00	\$135.00	< 1st
D0751	Crown, Porcelain Fused to Base Metal	\$284.00	\$650.00	\$660.00	\$725.00	< 1st
D0930	Prefabricated Steel Crown, Primary Tooth	\$73.03	\$152.00	\$146.00	\$175.00	< 1st
Endodontics						
D3220	Removal of Tooth Pulp	\$43.98	\$83.00	\$95.00	\$118.00	< 1st
D3310	Anterior Endodontic Therapy	\$177.99	\$420.00	\$426.00	\$509.00	3rd
Oral Surgery						
D7140	Extraction, Single Tooth	\$33.52	\$75.00	\$79.00	\$92.00	1st

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 TX Medicaid payment rates in 2004 (which were largely unchanged during the previous decade and remained unchanged until a federal court settlement in September, 2007). The next two columns show the median or 50th percentile charges for these services by dentists in the four West South Central states and in TX; while the second column from the right shows charges representing the 75th percentile of fees charged by dentists in TX. The far-right column shows the percentile equivalents for the TX Medicaid rates (i.e., the percent of dentists who charge the same or lower amounts than Medicaid paid).

As an example, the table indicates that for a periodic oral examination (D0120), the WSC regional and TX 50th percentiles of dentists' charges were \$27 and \$28, respectively. In 2004, the Texas Medicaid program paid \$14.72 for that procedure, an amount that no dentist in TX would see as equal to or greater than their current charges (i.e., < 1st percentile). That is to say, 100% of TX dentists would see the Medicaid payment rate as less than their usual charges, and a majority would see it as substantially less than their usual charges. The same can be said for 10 of the other selected procedures -- i.e., the respective Texas Medicaid payment amounts were less than the usual charges reported for any dentist in Texas, and below the cost of providing the procedure for the majority of Texas dentists. From an economic perspective, these payment levels which are substantially below the prevailing charges of the vast majority of TX dentists, and typical of Medicaid rates in many if not most other states, would not be expected to provide adequate incentives for dentists to participate in Medicaid.

In September, 2007, following a settlement in the federal court case of *Frew vs. Hawkins*, Texas EPSDT dental Medicaid reimbursement rates for 35 common procedures were raised by 100% (effectively to the 50th percentile of Texas dentists' fees). This action followed more than a decade of essentially stagnant dental Medicaid rates in the face of steady modest increases in the cost of dental care (~ 4.5% annually). Significant increases also were provided for approximately 20 additional relatively common dental procedures. Information recently obtained from individuals involved in the *Frew* case indicates that following the Medicaid reimbursement rate increases, the State has issued approximately 500 new Texas Medicaid dental provider numbers.⁴

Information obtained from these (and other) states which have implemented dental Medicaid reimbursement increases that brought their Medicaid payment rates into the range of what are considered to be 'reasonable market-based rates' have had a clearly positive impact on the number of dentists who provide dental services for children enrolled in Medicaid. Material regarding reimbursement rates and financing of dental services in Medicaid was included in the original version of the *Guide to Children's Dental Care in Medicaid* (the *Guide*) that was submitted by the American Academy of Pediatric Dentistry (AAPD) to the Centers for Medicare and Medicaid Services (CMS), but was redacted by CMS.

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
2. Actuarial Estimates of Necessary Funding Levels for Publicly-Financed Children's Dental Benefits Programs
 - a. American Academy of Pediatrics Analysis
 - b. Reforming States Group Analysis
3. Historic Funding Levels in Public Pediatric Dental Care Programs
4. Reimbursement for Dental Services
 - a. U.S. General Accounting Office Study
 - b. Comparisons of Medicaid Reimbursement Rates for Pediatric Dental Services to Prevailing Market Rates

⁴ In Texas a dentist may have more than one provider number (e.g., for dentists who practice in multiple locations).

- c. Global versus Selective Reimbursement Rate Adjustments
- d. Periodic Reimbursement Rate Adjustments
- 5. General Financing Considerations for Medicaid/EPSDT Dental Program Improvements

Additional information was provided in the *Guide* 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 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 in 2004 generally affirmed those findings. The actuarial information was included in the *Guide* to provide general 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).

b. Impact of Medicaid Reimbursement Rate Increases on Children's Use of Dental Services

Perhaps more directly to the point, the table below shows data from CMS 416 annual reports illustrating significant increases in utilization of dental services by children covered by Medicaid in five states following significant reimbursement rate increases. The increased use of dental services also constitutes a significant positive impact of Medicaid dental reimbursement rate increases.

	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	FY2006 CMS 416 % with Dental Visits	2006 vs. 1998 CMS 416 % with Dental Visits
AL	41,659	105,522	253%	151,581	364%	188,475	452%
DE	8,428	15,430	183%	18,269	217%	24,973	296%
IN	47,730	160,627	337%	212,909	446%	251,647	527%
SC	96,590	88,523	92%	245,297	254%	229,447	238%
TN	148,028	141,140	95%	249,252	168%	295,413	200%

The rate increases which have been implemented in these and a handful of other States were not done in isolation, and generally were part of a broader combination of actions designed to address issues which have been identified as chronic barriers to dentist participation and access to dental care in Medicaid.⁵ Although addressing these other issues is viewed as an important element of comprehensive dental Medicaid program reform, increasing Medicaid rates to reasonable market-based levels is critical to obtaining adequate levels of dentists' participation in Medicaid.

⁵ See series of briefs prepared by J. Crall and D. Schneider for the American Dental Association (available on the Medicaid and SCHIP Dental Association's website at <http://www.medicaidental.org/pubs/index.html>).

2. Advantages of No-risk Contractual Arrangements that Separate or 'Carve Out' Medicaid Dental Benefits from Global Medicaid Managed Care Arrangements

In addition to the essential step of raising Medicaid dental reimbursement rates to reasonable market-based levels, many States also have taken steps to implement no-risk, administrative services only (ASO) contracts that separate or 'carve out' dental Medicaid benefits from global Medicaid managed care arrangements. Examples include Michigan's Healthy Kids Dental Program and Medicaid dental programs in Connecticut, Maryland, Tennessee and Virginia. Such arrangements eliminate the need for subcontracting between global Medicaid managed care organizations (which often are not in the business of providing dental benefits) and dental benefits managers. This change not only helps to simplify program administration and reduce confusion among dentists and Medicaid beneficiaries alike, the no-risk aspect also helps to eliminate the inherent incentive in risk-based contractual arrangements for managed care organizations and/or dental benefits managers to reduce payments to dentists in order to enhance the intermediaries' profits.

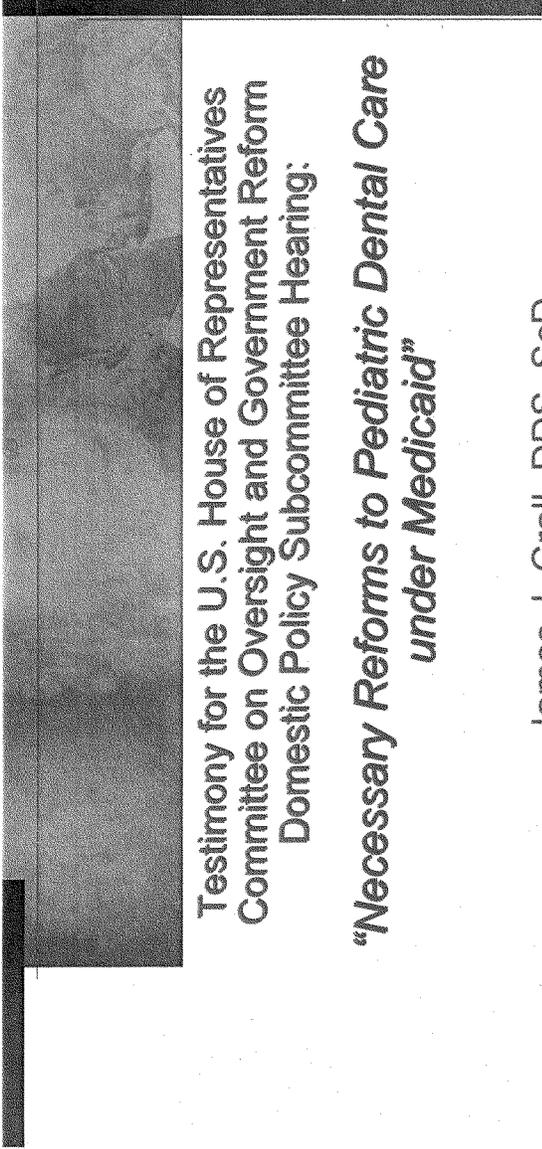
In addition to simplifying the administration of Medicaid dental benefits, these arrangements allow States to retain greater control in establishing reimbursement rates while affording reasonable profits for dental benefits managers. Additional advantages of the 'single-vendor' approach from the dentists' perspective include more streamlined enrollment procedures (because dentists do not need to fill out multiple enrollment forms and undergo credentialing by multiple dental benefits management organizations) and less confusion about program policies governing allowable services and billing processes which often results from having multiple dental benefits intermediaries involved within the same State (often within the same geographic region within a State). Moreover, contracting with a single dental Medicaid intermediary (single vendor) simplifies the contracting process, improves the ease of program monitoring, and has the potential for better contract enforcement on the part of the State Medicaid program.

Summary and Conclusions

In summary, several States have taken significant steps to increase dentists' participation and access to dental services in their Medicaid EPSDT programs over the past decade. Successful efforts generally have involved the necessary step of raising Medicaid dental reimbursement rates to reasonable market-based levels combined with additional steps to make Medicaid dental program administration more 'dentist friendly'. Streamlining provider enrollment and implementation of no-risk contractual arrangements that separate or 'carve out' Medicaid dental benefits contracting from global Medicaid managed care arrangements have been prominent parts of these strategies. In my opinion, promoting the adoption of these strategies by other States would help to substantially improve children's access to dental care in Medicaid.

Thank you for the opportunity to participate in this hearing.

James J. Crall, DDS, ScD.



Testimony for the U.S. House of Representatives
Committee on Oversight and Government Reform
Domestic Policy Subcommittee Hearing:

***“Necessary Reforms to Pediatric Dental Care
under Medicaid”***

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September 23, 2008
Washington, DC

Recent Medicaid Program Innovations

STATE	Adjustments Made to Medicaid Rates (Market-based Benchmarks)	Changes in Dentists' Participation in Medicaid Following Rate Increases	Months Between Rate Increases and Provider Participation
Alabama	100% of Blue Cross rates	+39% + 117%	24 44
Delaware	85% of each dentist's submitted charges	1 private dentist → 130 (of 378 licensed dentists)	48
Georgia	75 th percentile of dentists' fees	+546% (1,674 of 4,000) + 825% (60% of dentists)	27 48
Indiana	75 th percentile of dentists' fees	+58%	54
Michigan HealthyKidsDental	100% of Delta Dental Premier	+300%	12
South Carolina	75 th percentile of dentists' fees	+73% + 88%	36 42
Tennessee	75 th percentile of dentists' fees	+60% + 81%	4 20

<h2 style="text-align: center;">Medicaid Fee Comparisons</h2> <p style="text-align: center;">Comparisons with Dentists' Claims for Insured Patients in the ADA West-South-Central (WSC) Region and in the State of Texas</p>						
TX Medicaid Payment Rates for Selected Procedures			Comparisons with Dentists' Claims for Insured Patients in the ADA West-South-Central (WSC) Region and in the State of Texas			
CD14 Procedure Code	Procedure Description	TX Medicaid Payment Rate	WSC Region 80th Percentile	TX State 50th Percentile	TX State 75th Percentile	State Percentile Corresponding to TX Medicaid Payment Rate
Diagnostic						
D0130	Periodic Oral Exam	\$14.72	\$27.00	\$26.00	\$32.00	< 1st
D0150	Comprehensive Oral Exam	\$19.02	\$40.00	\$40.00	\$49.00	< 1st
D0210	Complete X-rays, with Bitewings	\$36.04	\$67.00	\$65.00	\$81.00	2nd
D0272	Bitewing X-rays - 2 Films	\$11.93	\$25.00	\$25.00	\$29.00	< 1st
D0330	Panoramic X-ray Film	\$32.54	\$65.00	\$65.00	\$75.00	1st
Preventive						
D1120	Prophylaxis (cleaning)	\$18.75	\$40.00	\$42.00	\$47.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	\$7.50	\$19.00	\$19.00	\$22.00	< 1st
D1351	Dental Sealant	\$18.55	\$33.00	\$35.00	\$39.00	< 1st
Restorative						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	\$43.73	\$88.00	\$91.00	\$107.50	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	\$52.57	\$110.00	\$119.00	\$135.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	\$264.00	\$650.00	\$660.00	\$725.00	< 1st
D2930	Prefabricated Steel Crown, Primary Tooth	\$78.03	\$152.00	\$146.00	\$175.00	< 1st
Endodontics						
D3220	Removal of Tooth Pulp	\$43.98	\$93.00	\$95.00	\$118.00	< 1st
D3310	Anterior Endodontic Therapy	\$177.99	\$420.00	\$426.00	\$509.00	3rd
Oral Surgery						
D7140	Extraction, Single Tooth	\$33.52	\$75.00	\$79.00	\$92.00	1st

Mr. KUCINICH. Thank you very much, Dr. Crall.

I would like to go to questions of members of the panel. We will begin with Ms. Tucker.

In conversation with my staff, you mentioned that the number of dentists in Maryland is so limited that, even if they all enrolled in the Medicaid provider network, you still would not have enough dentists to service the State's Medicaid population. What are you doing to increase the number of dentists in Maryland, or what are you thinking of doing?

Ms. TUCKER. What have we been doing and what are we going to be doing?

Mr. KUCINICH. Yes.

Ms. TUCKER. We have entered into dialog with our Maryland chapter of the Dental Association and other dental associations in Maryland, and we have asked them to come to the table and participate in the Medicaid program. We have told them that we will increase payment rates, and we did in July.

They just had their annual meeting. At their annual meeting, we had all our dental vendors there and helped them enroll in the program, so we actually had people there and assisted with that.

In the long run, we are moving toward a single vendor, which is one administrative service organization that is fee-for-service. The dentists have said that they will be more likely to participate, and many have said they won't participate until that move is made.

So we have kind of been working on short-run efforts. We did enroll people during the last week at the convention, but we are also looking at the long-term changes.

Mr. KUCINICH. Well, you have obviously made some great strides in your pediatric dental program.

Ms. TUCKER. Right.

Mr. KUCINICH. What has provided the political will for such a change?

Ms. TUCKER. Which provided what?

Mr. KUCINICH. What has provided the political will for the strides that you have made in improving pediatric dental care?

Ms. TUCKER. I think the fact that it is a new Governor. This terrible tragedy occurred in our State. He made it a major priority of his administration. He pulled together all of the important stakeholders throughout the State, and our Secretary chaired the Dental Action Committee. We had everybody at the table making recommendations. Everybody was committed. They made very concrete recommendations that we could actually carry out.

Mr. KUCINICH. And could you tell me what have you learned about having multiple MCOs providing pediatric dental care to Medicaid enrollees?

Ms. TUCKER. Well, one thing that we learned, during the time when we had implemented the health choice program we actually had seen increases in utilization of services for children, but it wasn't enough. What we did learn was that this provider community is not willing to accept any administrative burdens. It is a provider community that actually doesn't like insurance as a whole, and is very able to survive with patients that are private fee-for-service patients. So one thing that we learned was that any administrative burdens caused by having multiple organizations was a

real problem for this provider community. That was one thing that we definitely learned, and we are moving forward with this single vendor because of that.

Mr. KUCINICH. Thank you very much.

Dr. Grover, the New York Times reported that the number of dentists in the United States has been roughly flat since 1990 and is forecast to decline over the next decade. Can you tell us how many dentists graduate each year and how many retire? Also, what is the total number of dentists? Is there a dentist shortage? How do we meet the growing public need for oral health services with the population of dentists remaining static?

Dr. GROVER. Well, the particulars of the number that graduate from the 57 dental schools that we have now I don't have with me right now, but I would be happy to provide that. I can say that there are seven new dental schools that are opening, and the number of dentists in this country, some may say that there is a maldistribution of dentists. Clearly, there are dentists needed in areas where there are currently no access to oral health services. And there are States that are experimenting with loan forgiveness and other incentives to attract providers to those areas.

The exact number of dentists that are retiring is a fuzzy number. There are some that retire and then come back into practice. We have had a private practitioner retire and came and joined our staff at our health center. It is a fluid number.

Mr. KUCINICH. Thank you. In your testimony you discuss a community dental health coordinator who would be responsible for such dental procedures as fluoride and sealant applications, as well as performing temporization on dental cavities with materials designed to stop the cavity from getting larger. What is the difference between a community dental health coordinator and a dental hygienist, and if a difference exists, why can't a dental hygienist perform these procedures?

Dr. GROVER. Well, a dental hygienist can do the duties that we have outlined with the community dental health coordinator. The difference is that a hygienist is most effective and most productive in performing clinical services with a dentist. The community dental health coordinator is meant to be a community worker with oral health skills. That is a person who helps these wonderful people navigate a very complicated system, helps get families enrolled, helps patients keep their appointments, and helps with transportation issues, which in my personal experience is one of the biggest barriers that this population faces.

So the community dental health coordinator is certified, not licensed, and can perform procedures, but primarily functions as a navigator and oral health educator.

Mr. KUCINICH. You mention that one of the reasons dentists are not interested in participating in Medicaid is because of the administrative burdens. Do you believe that carving out dental from managed care structure would work to ease those burdens and therefore attract more dentists?

Dr. GROVER. Well, I can only speak from the Healthy Kids perspective. I know what a success it has been in Michigan. I know that in my health center we have had great success with helping our community become more involved. Healthy Kids dental has

been a success story in Michigan because of the streamlining that they have done. Other MCO organizations I can't really speak for.

Mr. KUCINICH. Thank you very much.

Dr. Crall, in your testimony you suggest that risk-based contracts have a built-in incentive to reduce payments to dentists who provide dental services to Medicaid beneficiaries. Why is that?

Dr. CRALL. Well, basically if the organizations are paid on a capitated basis it creates an incentive to reduce their payout. That contributes to their bottom line. There are multiple ways in which that can be done. If reimbursement rates or payments to dentists are kept low, that will suppress the supply of services. If administrative burdens are put in place that require preauthorization that isn't consistent with what dentists experience in other commercial plans nor plans that are not risk-based, then those are ways in which the supply of dental services will be constrained, which contributes directly to the bottom line of the organization.

Mr. KUCINICH. So why do States continue to enter into risk-based contracts in MCOs?

Dr. CRALL. States, certainly over the period of the last decade or so and in the current climate, are faced with some fiscal pressures, budgetary pressures.

Mr. KUCINICH. That is why you would maintain—

Dr. CRALL. And the global managed care arrangement is a way to sort of try to cap the increases in the health care costs.

Mr. KUCINICH. Do you have any opinion on whether States should enter into non-risk-based contracts?

Dr. CRALL. I will reiterate the opinion in my testimony, which is, in fact, I think, that non-risk-based approaches such as was used in Tennessee in a global managed care arrangement that was very much risk-based, when the dental piece was carved out in Tennessee there were substantial and very rapid sort of increases in dentists' willingness to participate, and in the State's ability to manage that program more effectively.

Mr. KUCINICH. Well, you kind of answered part of this previously, but States have a limited amount of funding, have to make difficult decisions on how to allocate. If States were considering increasing reimbursement rates for a limited number of procedures, which ones would you recommend be prioritized?

Dr. CRALL. Without getting into too much detail, I was involved both with some of the workings in the State of Texas as well as the State of Connecticut recently, and there are a relatively small number, 50 to 60 perhaps, set of procedures when you are talking about pediatric dental care that cover the vast gamut of common procedures that children need. If States concentrate on making those rates attractive to dentists, they can both be fiscally responsible and improve access to care.

Mr. KUCINICH. I would really appreciate it if, for this committee, if you would, as a followup, give us a letter that would recommend, based on your experience, kind of a prioritization.

Dr. CRALL. I would be happy to do that, Mr. Chairman.

Mr. KUCINICH. That would be helpful.

I would like to go to Dr. Casey.

How has adopting a preventive disease model both improved the oral health of children and helped North Carolina reduce Medicaid costs?

Dr. CASEY. As of this time, Mr. Chairman, we have not been able to demonstrate cost savings, but additional research is ongoing. We are looking at pay claims over a long period of time, up to 7 years of age. So you have to understand that it is a complex research issue, and we hope in the future to demonstrate cost savings to our program.

Mr. KUCINICH. Did you have any plans to enhance that program model?

Dr. CASEY. I am sorry?

Mr. KUCINICH. Do you have any plans to enhance the preventive model?

Dr. CASEY. Yes, we do. We are actually working on a pilot model—and I address this a little bit in my written testimony—a pilot model to facilitate referrals from participating physicians to general dentists who have been trained to see kids in this age group, zero to 3½ years of age.

Mr. KUCINICH. So if States were interested in creating a prevention and disease control model, how would they go about doing that? What would you recommend?

Dr. CASEY. Well, I would recommend modeling their program after something similar to ours. Other States have addressed the issue, as well.

Mr. KUCINICH. Now, did you get support from CMS when you did that?

Dr. CASEY. We did.

Mr. KUCINICH. And so, from your experience, if the States contact CMS at this point they would be ready to assist them, based on your experience?

Dr. CASEY. I think that CMS in disseminating information of best practices, we plan to apply for a promising practices designation for CMS to help them spread the word about our program.

Mr. KUCINICH. Thank you.

Mr. Finnerty, you mentioned that one of the reforms adopted by Virginia was strengthening its relationship with the State's dental community. Can you describe what that entailed and how it worked to improve access and utilization of pediatric dental care?

Mr. FINNERTY. Mr. Chairman, I think that is probably the most important thing that we did. Before we put into place any of the reforms that we were able to achieve, the first thing that I did as a Medicaid Director was to sit down with the Executive Director of the Virginia Dental Association and say, "what do we do to fix this program?"

We started a dialog actually 2 years before our reform program actually went into effect, and the relationship that we have developed not only helped to develop the program, but once we had the program in place they were one of our biggest advocates in trying to go out to their membership to say, Look, the State has done what we have asked for. Now you all need to step up and join this program and treat these kids.

It has been absolutely essential to it.

Mr. KUCINICH. Why did you decide to increase reimbursement rates? Did you think increasing reimbursement rates would have been enough to improve access and utilization?

Mr. FINNERTY. We increased the rates because they were very, very low, particularly on some codes. They were less bad, if that is the proper English, in some areas, but very, very bad in others.

In terms of whether or not that would have been enough to get increased participation, I think it would have helped, but I really don't think that it was sufficient. I think that it was a necessary part of the reforms, but without making the administrative changes to the program I really don't think it would have had the impact that the combined effect has had or the combined effect of both administrative reforms and fee increases.

Mr. KUCINICH. So how did carving out dental out of the MCO model impact access and utilization?

Mr. FINNERTY. That, along with the fee increases, as I mention in my testimony, has increased our utilization quite significantly for children 3 to 20. We have seen a 55 percent increase in utilizations from just prior to the start of our new program, 2 years hence from that point in 2007. So it has had a major effect. We would not have seen those increases without the changes, I am very confident.

Mr. KUCINICH. Now, in your testimony you mention that the disruption of enrollment can disrupt care. Why is that the case?

Mr. FINNERTY. Well, when a child is receiving ongoing dental care in Virginia, children can move between managed care organizations. We have five of them that we contract with. If a child is receiving ongoing care, if the child moved from one plan to another and the dentist that was treating the child initially is not a participating dentist in the other plan, then that child is going to have to find another provider, and so that is transitioning the care to another provider and that type of thing.

Under our streamlined program, all of the dentists participate and contract with one vendor, so, regardless of what health plan they are in, they get their dental care through one plan, and that has virtually been eliminated, the problem of transitioning.

Mr. KUCINICH. Thank you, Mr. Finnerty.

Ms. Lowe, according to your testimony, utilization of dental care in Georgia did a turn-around between 2001 and 2007. What do you think CMS could have done to stop this deleterious trend?

Ms. LOWE. What could CMS have done, sir? I am sorry, I didn't hear the last part.

Mr. KUCINICH. What could CMS have done during that period?

Ms. LOWE. I think that the State was actually making progress during that period because of the changes in the fees, which went up, and also the changes in the administrative approach to things, which greatly simplified how things were going. That was over the period of 1999 to 2004.

Then, when the State eliminated those 11 dental codes from payment, things crashed, and it crashed in the treatment area.

So possibly if CMS had said, sorry, you can't eliminate payments or reduce payments for those codes, that would have made a difference.

Mr. KUCINICH. Well, did increasing reimbursement rates by 33 percent have any impact on access and utilization?

Ms. LOWE. Yes, it did. I think that was a major contributor to the improvements that we saw over a period of years, but it was pretty shocking how fast it could crash just because of the budget cuts that subsequently took place.

Mr. KUCINICH. So tell us what Georgia did to reform its pediatric dental program under Medicaid, in a nutshell.

Ms. LOWE. In a nutshell, what they did over several years was to raise the fees quite substantially until they were at the 75th percentile. They also initially, when we were still operating our payment system under the old EDS, which was actually a DOS-based system and quite antique, at least standardized the forms and used standard dental codes, which had not been done before. Those two things together made a big difference.

And then the State also changed to ACS from EDS and brought the State into a Windows-based system for processing claims, and that made a big difference eventually. It was a rocky start, but eventually it made a big difference in the way providers were able to file claims. They were able to check out claims online. They were able to check eligibility online.

After that, after those improvements actually led to increases in utilization and in the number of dentists participating, the State did the budget cut, which eliminated payment for some of the codes, and then decided that they would require the children to enroll in capitated managed care. So we have had those two disruptions.

Mr. KUCINICH. Thank you very much.

I don't have any further questions of the panel. Does Mr. Cummings have any questions?

Mr. CUMMINGS. I just have a few questions, Mr. Chairman. I apologize. It has been a very hectic day. I apologize to our witnesses, but I am glad you are here.

Ms. TUCKER, I have said many times that, in light of Deamonte Driver's death, I was glad to see that Governor O'Malley convened the Dental Action Committee to try to improve children's access to dental care. Out of Deamonte's death—I am sure it has been mentioned already—a lot of what we are doing now came out of that. His death has had a profound impact.

I was further pleased to learn that the Dental Action Committee adopted all of the recommendations that I provided to the Governor, which is very unusual. I think the Governor took this situation very seriously. And, of course, we will be closely watching to see what goes on from here.

One of the changes that is currently in progress is the move to a single vendor for providing Medicaid dental services in the State of Maryland. Where are we in that process?

Ms. TUCKER. We issued the RFPs in the early part of the summer, and all of the proposals were due at the beginning of September. We received five huge responses. Currently there is a RFP Procurement Committee process going through to analyze all of the different vendors. It was a very, very complex RFP. The requirements were quite extensive. So that committee is going through

and is in the process of picking the best of the five people or groups that applied.

The goal will be to have that whole process done by the beginning of December so it can go to our Board of Public Works in January and be awarded so that we can begin the transition to the new vendor starting March 1st.

Mr. CUMMINGS. What kind of oversight do you anticipate there being with regard to the vendor once they are chosen?

Ms. TUCKER. The deliverables are quite extensive and incredible, so there will be a lot, and there will be a lot of oversight for this particular project. The Dental Action Committee didn't go away after they put forth their proposals. They are still an action committee. They are still going to be involved. But the State, the Health Department will be extremely involved in the day-to-day monitoring of that contract.

Mr. CUMMINGS. Now, Dr. Grover, again, I want to thank you for your testimony also and thank you for all that you are doing for children in Michigan, but I think your work is truly an example of what dentistry has the power to achieve. I am pleased also with many of the things that the American Dental Association has done to improve children's access to dental care across the country.

I am concerned, however, that some actions by the ADA may have the opposite effect. You mention in your testimony the ADA's recognition that a work force shortage exists in the dental field and that alternate models need to be explored, and I appreciate that recognition. But you also describe the ADA's recognition for such a position as the community dental health coordinator. I think this model is a solid concept and it ought to be tested, but I do think other models ought to also be tested.

Do you agree with this concept that other models of an alternate dental provider should be tested?

Dr. GROVER. I think that alternate models of providing dental services, if they involve irreversible procedures, could be potentially dangerous. In my experience as a dental director, where I see the need to be the greatest is in helping families work through the system and helping families keep appointments, have transportation, and handle some of the cultural and language barriers. Those models—and we have three sites which are going to be piloted—will help the dental team be more productive.

I think the challenge is in working with the families not only to prevent disease but to navigate the system, which can be quite burdensome for families to understand.

Mr. CUMMINGS. Well, we saw that in the case of Deamonte Driver. The mother of Deamonte, as you are, I am sure, well aware, when trying to get services for his brother contacted over 40 doctors who said that they would take patients on Medicaid, and they weren't able to accomplish that. They even went to a lawyer type person to try to help them, like a legal type clinic, and still had problems. It is interesting. I notice that what you just said, you brought up something that I have heard dentists bring up over and over again, and I never thought of it until we got involved in this issue, and that is the issue of people keeping appointments. The dentists tell us that one of the reasons why they are not that interested sometimes in doing this kind of work is because the popu-

lation that they deal with, of course, don't show up for appointments. Time is money, and they have but so many appointments they can set in a day, and of course when people don't show up they don't make money.

So the pilots that you are talking about, how do they address that issue?

Dr. GROVER. Well, the pilot program, for example, in Jackson County, would help families that have appointments at my dental clinic in my health center and would help us track people who miss appointments. There is a variety of reasons why people miss appointments. But confirming those appointments and calling and, in fact, visiting the home of the family where there is a missed appointment can help us track those children more effectively and get them the care that they need. I think that would complete the puzzle, because, quite honestly, I see that as a huge barrier to folks. And it is not enough just for my health center, which has a van, and my health center, which confirms appointments, but to have somebody go to the home, to have somebody work with the mom.

There are some community health workers in California that do that, to help track these kids and make sure nobody falls in between the cracks. There are too many that is happening to.

Mr. CUMMINGS. Well, you know, it is interesting that when you look at the way mothers take care of newborns, there are certain things that seem to be clear that they must do, and they do them. I think when you look at things like crib death, things of that nature, the word has gotten out that you do certain things to make sure that your babies survive. I am just wondering, could we do a better job with regard to dental education? I am sure you may all have gone over this. It seems to me that a lot of people don't have a clue about how significant the relationship is between the teeth and the rest of the body. Not a clue.

So I would think that a mother and father, if they really had a clear understanding of this relationship, that might be helpful in, one, them staying on top of their dental appointments and making sure that they made them, because I don't think that when you get that well baby appointment—is that what it is called?

Dr. GROVER. Yes.

Mr. CUMMINGS. I don't think a lot of people go about missing those appointments. They know that they have to do these things. But it seems to me that if people really know that the health and perhaps the life of their child is dependent upon them taking certain actions, it seems to me that you might get some results there.

One of the things that we try to do in the SCHIP bill, which the President vetoed twice, was a provision in it whereby mothers would be exposed and fathers exposed to information about dental care from the very beginning, from before the child is born. They would be educated on that and provided pamphlets, things of that nature.

I am just wondering what do you all do in that regard, and what is ADA's position in that regard?

Dr. GROVER. Well, the ADA position, you are absolutely correct on many points. The ADA's position is to encourage a dental home, and the first dental exam by 12 months of age.

What we are doing in Michigan, in particular, is we are having a pediatric oral health summit where physicians and dentists are coming together so that the physicians know what they can talk and discuss with the mom. We at our health center do have OB visits, particularly scheduled in special slots, because we know that a significant factor in children receiving oral health care is if the mom receives oral health care. That is a big component.

I have also recently worked on a DVD for Delta Dental on infant oral health care, and we would look forward to Delta distributing that nationwide.

Education is key, as you have pointed out correctly.

Mr. CUMMINGS. And what does the ADA want the Congress to do? I am sure you have testified. What would you like to see us do?

Dr. GROVER. Well, we have an Essential Oral Health Care Act, H.R. 2472, which we feel is key, but also to encourage CMS to adopt some guidance for States that are making some headway, that are making some successes, and encourage States to develop similar models.

I think the rising tide lifts all the boats, and I think what goes on in one State could go on in another.

I think we need to work at making oral health part of our cultural conversation, and I don't know that is totally up to Congress, but I am sure that would be a big help.

Mr. CUMMINGS. All right. I don't have anything else.

Mr. KUCINICH. I thank Mr. Cummings for the excellent work that he has done on this matter from its inception, so thank you very much for your presence here.

I want to thank the witnesses.

This has been a meeting of the Domestic Policy Subcommittee of the Oversight and Government Reform Committee. The title of today's hearing has been: Necessary Reforms to Pediatric Dental Care under Medicaid. We have had two panels, and I want to thank the members of the second panel for your contributions. Each of you has helped to sharpen this committee's awareness of where we have been, where we are headed, and what can be done to improve pediatric dental care for the Nation's children. Thank you for your own individual commitments in that regard and the work that you have done in your respective capacities on not only practice but in the States, as well.

I want to thank the Members and the staff who have participated, and the staff, in particular, for the excellent work they have done in researching this from the beginning.

Without any further comments, and finally with the unanimous consent request to insert the testimony of Burton Edelstein into the record, this committee stands adjourned.

[The prepared statement of Mr. Edelstein follows:]

FOR THE RECORD ONLY

***Testimony
Of
Burton L. Edelstein DDS MPH***

Founding Director
Children's Dental Health Project of Washington, DC
Professor of Dental Medicine and Health Policy & Management
Columbia University

***DOMESTIC POLICY SUBCOMMITTEE
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
Tuesday, September 23, 2008
2154 Rayburn HOB
10:00 a.m.***

"Necessary Reform to Pediatric Dental Care under Medicaid"

As Founding Director of the Children's Dental Health Project (CDHP) and Director of the Maternal and Child Health Bureau's *National Oral Health Policy Center at CDHP*, I am pleased to respond to the Subcommittee's request for testimony on policy recommendations to improve the oral health of children in Medicaid. This testimony is supported by federal studies and by analyses conducted at Columbia University where I serve as Professor of Dental Medicine and Health Policy & Management.

The Subcommittee's finding that only a minority of Medicaid-enrolled children in Maryland obtain dental care, that many children go years without care, and that the majority of care is provided by a small subset of dentists typifies the situation nationally.

Medicaid reaches only one-third of child beneficiaries nationally

The Agency for Health Care Research and Quality reports that nationally 58% of children with private dental coverage obtain care in a year while only 34% of children in Medicaid and SCHIP do so. The Center for Medicare and Medicaid Services' data similarly show that by 2006 only 33% of Medicaid-enrolled children obtained a dental visit – up from 22% seven years earlier. Much of this increase may be attributed to Medicaid expansions that resulted from SCHIP enactment in 1997 while some may be attributed to state-level program reform. By 2006, the latest year for which CMS data are available, reported utilization across states ranged as high as 44% and as low as 19%.

Disease trends are outstripping capacity

Program performance fails profoundly to keep pace with the growing dental disease burden in the beneficiary population. CDC reports that early childhood tooth decay is trending upward, affecting more than one-quarter (28%) of US 2-5 year olds and impacting a higher percentage of poor and low-income children. Coupled with demographic trends, the volume of disease and associated treatment needs are increasingly outstripping program capacity. (States report that an increasing percentage of children are born under Medicaid and Census reports that more children were born last year than at the peak of the baby boom),.

State dental Medicaid reforms improve but do not correct shortcomings

States often have little incentive to address shortcomings in their dental Medicaid performance because of limited federal oversight and lack of sanctions for poor performance, the relatively small size of the dental program within Medicaid (about 5% of Medicaid expenditures), the lack of provider demand or beneficiary voice, and the small staffs serving this component of the multifaceted Medicaid program.

A small number of states, however, including DE, IN, MI, SC, TN, and VA, have made notable dental Medicaid program improvements. Even these efforts typically yield levels of care far lower than provided to privately-insured children (DE 29%; IN 41%; MI 37%; SC 43%, TN 36%, VA 32%). This may be attributed in part to lack of care-seeking behavior by beneficiaries but is more likely due to the lack of available providers.

Dentist participation in Medicaid is low and insufficient

With few exceptions, less than half of dentists enroll as providers. Even in the states recognized for their major reforms - reforms that have included market-based fee increases - fewer than half of dentists are enrolled in all but SC (40% in DE, 37% in IN, 37% in MI, 27% in TN, 25% in VA). Among dentists who enroll as Medicaid providers, often with the encouragement of their state dental associations, only a small percentage actively provide significant levels of care as earlier reported by the Subcommittee.

Attendees at a recent dental association symposium on Medicaid noted, as did the Subcommittee, that many self-identified Medicaid dentists are such “virtual providers” who enroll but do not provide services under the program. Among barriers conjectured by attendees were “fear of practice being overrun by Medicaid patients,” feeling among older dentists they have previously served Medicaid populations and that it is now the responsibility of younger practitioners, discomfort caring for young children, and misinformation about the population.

Dentists often note that their business model does not readily accommodate discounted public insurance plans and some state payment rates are indeed too low to allow for all but marginal volume of services to beneficiaries. However, among some of the dental practices that successfully serve large numbers of child beneficiaries are those affiliated with multi-state Medicaid-specific management companies. These practices typically locate in impoverished areas along public transportation routes where physical access is assured and organize their schedules in ways that best accommodate the most socially disadvantaged of the beneficiary population.

Higher payment rates are necessary but not sufficient to improve performance

It is widely appreciated that paying providers at adequate rates is a necessary but not sufficient condition for improving dental access for Medicaid-enrolled children. In addition to reforming payment rates to levels that reflect market conditions, successful reforms also actively and continuously engage state dental associations as partners, streamline administration, and provide facilitation services to both beneficiaries and dentists.

A group of 30 dental Medicaid experts were recently polled by Columbia University researchers on factors required to improve Medicaid dental programs. The six categories of action recommended were (1) developing an adequate provider network, both numerically and geographically; (2) providing adequate funding; (3) ensuring supportive program administration; (4) fostering a political, professional, and advocacy climate that encourages change; (5) delivering comprehensive beneficiary assistance; and (6) addressing program design issues including continuous eligibility, single point of administration, and accountable contracting with vendors.

Not all fee changes lead to utilization improvements.

A Columbia University study of dental Medicaid performance over the years 1999-2006 identified 41 states that reported fee increases but only 25 of these also showed an increase in utilization, likely because the others’ increases were insufficient. However, even among the 25 states whose fee increases are associated with utilization increases,

only 13 states reached utilization levels of 33% or more. *Improved* levels of care ranged from 19% to 43%. No state experienced improvements in utilization if they did not also raise fees. The ongoing study will further analyze the relationship between program reforms, including fee changes, and attainment of utilization rates that exceed the national average. Notable were some states, particularly those that are rural or frontier, in which utilization rates exceed the national average despite low fees. Conjectured is that in such states the professional culture, role of dentists in their communities, lower dentists' operating costs, personal relationships, and/or larger proportion of children in Medicaid lead to more equitable care across income strata.

Managed care risk-contracting contributes to the problem of low utilization

States frequently contract with managed care vendors to develop networks, manage claims, and administer their dental Medicaid programs. When states put those contractors at financial risk without establishing rigorous performance accountability standards and allowing compensation for unanticipated increases in utilization, they establish a powerfully perverse incentive for underutilization. The greater the utilization, the greater the risk that vendors will not only lose profit but will expend more dollars than they take in as premiums.

This constraining condition can be eliminated by rewarding rather than punishing vendors for improved utilization. State Medicaid contracting could be better modeled on federal contracting for its Military dependent dental program in which the vendor is financially incentivized for increased utilization and encouraged to promote oral health and dental care among beneficiaries.

Disease management is critical to improved health at lower costs

In the big picture, however, disease burden will overwhelm any and all efforts to repair children's cavities because the sheer volume of cavities in need of fillings swamps the capacity of the public and private dental delivery systems. Improved health outcomes at reduced costs can only be accomplished through a fundamental shift in the nation's approach to dental caries management in children.

Cavities result from an infectious, transmissible disease process that is typically established in children's mouths before age two and that plays out over a lifetime. "Dental caries" is overwhelmingly a dietary disease that results from high frequency ingestion of simple carbohydrates and can be well suppressed through the use of fluorides.

Each child has a unique level of risk for this disease and would benefit from appropriately tailored preventive and management strategies. The one-size-fits-all semiannual cleaning and fluoride approach to cavity prevention commonly practiced today starts too late for meaningful prevention and misses opportunities for *bona fide* disease management through individualized care plans like those used to manage asthma and diabetes in children. Needed are family-centered behavioral interventions coupled with pharmacologic interventions that are instituted early in affected children's lives, coupled with public education about caries as a manageable disease.

Findings of over 40 years of laboratory and applied research by the National Institute for Dental and Craniofacial Research awaits implementation in the form of refined clinical protocols that can be demonstrated to delay disease onset and reduce population-level disease burden. Implementing such practices, however, will require changes in provider education, public awareness, financing arrangements, and practice staffing and organization.

Policy recommendations

Among specific public policies that arise from these observations are the following.

1. To address Medicaid-provider shortages:
 - a. Authorize and support programs that identify and address root-causes of private provider willingness to care for children in Medicaid including programs that correct stigma, improve provider education, and incentivize dentists. Markedly increased funding for the HRSA *Grants to States to Support Oral Health Workforce Activities* program in more than 18 states.
 - b. Address workforce shortcomings by considering opportunities for advanced US training of dentists educated outside of North America and for “midlevel” providers, and by engaging outreach workers and peer-counselors in locales and programs where at-risk children live, learn, and play. Through these personnel, further integrate oral health into WIC, Head Start, early intervention, and early education programs.
 - c. Incentivize dentists to serve in the public delivery systems through expanded scholarship and loan programs.
2. To address state Medicaid dental program performance
 - a. Direct CMS to intensify oversight of state programs, issue clarifying guidance, promote and disseminate best practices, provide or contract for technical assistance to states, and prohibit those risk-based contracting practices that results in incentives for underutilization.
 - b. Authorize and fund grants to states to engage technical support for development of dental Medicaid program infrastructure including personnel, processes, provider relations, and enhanced contracting.
 - c. Fully fund the CDC dental public health infrastructure and implementation grant program beyond 12 states so that all states develop the public health capacity to partner effectively with, and provide expertise to, state dental Medicaid programs.
 - d. Establish an outcomes and cost-effectiveness demonstration program of Medicaid early childhood disease management interventions.
3. To address the growing disease burden and improve health outcomes at lower costs:
 - a. Authorize and adequately support research on clinical practice transformation and education of dental and medical professionals to expand their engagement in non-surgical pediatric caries management.

- b. Create at CDC a national public awareness and education program on caries understanding and prevention.
- c. Establish federal support for state Medicaid program demonstrations on early intervention, individualized care plans, and disease management.
- d. Create programmatic incentives to address the overwhelming lack of dental care provided to pregnant women both to improve their oral health and to reduce risk for disease transmission to the next generation.

Retain past Congressional legislative successes

Congress can significantly improve children's oral health and dental care by ensuring that all of the dental provisions that it adopted in passing the vetoed Child Health Insurance Reauthorization Act are retained in future legislation. These include ensuring dental services as part of well baby-well child care; requiring uniform state reporting on program performance; informing parents at their children's birth about risks for early childhood caries and its prevention; promoting development of quality measures for children's oral healthcare; facilitating public-private contracting, and investigating the roles for mid-levels of various types in improving oral health and healthcare.

Conclusion

Among health conditions afflicting America's children, including autism, asthma, diabetes, and tooth decay, tooth decay remains the single most common condition and is consequential to millions of children's lives because of the pain and infection that it produces. But among these conditions, tooth decay is uniquely preventable and, once established, readily manageable. The way out of so much current suffering is early and effective prevention and disease management coupled with ready access to reparative surgical care for children whose mouths are already damaged.

[Whereupon, at 1:25 p.m., the subcommittee was adjourned.]
[Additional information submitted for the hearing record follows:]

ELIJAH E. CUMMINGS
7TH DISTRICT, MARYLAND

COMMITTEE ON
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CHAIRMAN, SUBCOMMITTEE ON COAST
GUARD AND MARITIME TRANSPORTATION
SUBCOMMITTEE ON HIGHWAYS AND TRANSIT
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COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON READINESS
JOINT ECONOMIC COMMITTEE
SENIOR WHIP

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

October 1, 2008

Jane S. Grover, D.D.S., M.P.H.
First Vice President
American Dental Association
211 East Chicago Ave.
Chicago, IL 60611-2678

Dear Dr. Grover:

Thank you for your testimony in the September 23, 2008 hearing of the Committee on Oversight and Government Reform's Domestic Policy Subcommittee entitled, "Necessary Reforms to Improve Access to, and Utilization of, Pediatric Dental Care Under Medicaid."

I appreciate your response to my questions, however time did not allow for me to complete the line of questioning I had prepared. Specifically, I request that you provide responses to the following for the record no later than Friday, October, 10, 2008.

- In response to my question regarding the need to test alternate models for a midlevel dental workforce professional, you emphasized your support the American Dental Association's recommendation for such a position, the Community Dental Health Coordinator, over other proposed models. To clarify the record, is it then the ADA's position that no other model ought to be tested?
- I am very concerned with the ADA's hard line against models other than its CDHC. You expressed your association's support for legislation that I have introduced, "Deamonte's Law," H.R. 2371, which I appreciate. What you did not note, however, is that the ADA has raised objections to expanded legislation that I introduced with Senator Sherrod Brown of Ohio, H.R. 5549, the "Deamonte Driver Dental Care Access Improvement Act of 2008." Specifically, the ADA was very concerned with language in that bill to test alternate models for a midlevel dental provider. We did not say which models ought to be tested, just that they ought to all be tested so that the best model could be accredited. But the ADA vehemently opposed this section of our bill. In fact, your association threatened to lobby against the bill if we did not expressly endorse the ADA's model for a midlevel provider. Do you think this is the best way to get our children access to care, Dr. Grover?

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- One of the many concerns that I have heard raised is that children simply do not have a dental home in the same way that they have a medical home. Parents have a tendency to take their child to the doctor, and they typically comply with annual well child visits as well. But they are less likely to recognize and meet their child's dental needs—they think their teeth are “just” baby teeth, and will fall out anyway. What we know, however, is that this is a dangerous line of thinking and often leads to a lifetime of dental disease. I think we have an opportunity to reach children in the pediatrician's office, where we know they already are. What has the ADA done on this front?
- I think that dentists ought to be doing all that they can to engage pediatricians, to reach these children before the dental decay gets out of hand. Just think of what a difference it would make if all pediatricians were encouraged to look in a child's mouth, not just down his or her throat, and make a referral to a dentist if visible cavities were present. Another key opportunity here is for pediatricians to apply fluoride varnish to the teeth, to help arrest dental decay before it starts. Does the ADA have a position on training pediatricians to do this?
- Finally, I appreciate your association's efforts to reach out to children, particularly on Give Kids a Smile Day. I participated in the event last February in Baltimore at the Dr. Samuel D. Harris National Museum of Dentistry, and I was moved by all the dentists and dental students who came out to help these children. People want to help these children. I hear this from the dentists who visit with me on a regular basis. My question is, are we giving them enough opportunities to do so? Has the ADA considered expanding its program to give kids a smile every day, not just once a year?

Thank you in advance for your prompt response. Any questions regarding this request can be directed to Ms. Danielle Grote on my staff, who can be reached at (202) 225-4741 or danielle.grote@mail.house.gov.

Sincerely,



Elijah E. Cummings
Member of Congress

cc: The Honorable Dennis J. Kucinich, Subcommittee Chairman
The Honorable Darrel E. Issa, Subcommittee Ranking Member

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October 8, 2008

The Honorable Elijah E. Cummings
United States House of Representatives
2235 Rayburn House Office Building
Washington, DC 20515-2007

Dear Representative Cummings:

I am writing in response to your letter to Dr. Jane S. Grover following the Committee on Oversight and Government Reform's Domestic Policy Subcommittee September 23, 2008 hearing entitled "Necessary Reforms to Improve Access to, and Utilization of, Pediatric Dental Care under Medicaid."

Your letter raises a number of important issues that I would like to address.

The American Dental Association (ADA) believes the best way to improve access to oral health care is to support federal and state legislation that address three areas of concern, as detailed in our written testimony to the subcommittee. First, we need to properly fund Medicaid and SCHIP and make other changes necessary to bring many more private sector dentists into those programs. Second, more needs to be done to influence the distribution of dentists, such as the use of tax credits, student loan repayments, and programs to link dentists interested in practicing in underserved communities with local community leaders who are willing to help underwrite such practices. Third, we need initiatives to strengthen the delivery system in ways that truly address the root causes of the lack of oral health access, and that provide more consistent support for the oral health infrastructure which, in turn supports community-based prevention programs.

At this time, the ADA does not support the development of a mid-level provider in the dental workforce because there is no evidence that such a provider can address the barriers to oral health access facing the underserved populations in our nation. Now, more than ever, it is vital that we devote government and private resources to activities that have been proven to work.

We are extremely concerned that policymakers have become enchanted with the mistaken idea that a mid-level dental provider could serve as a low-cost alternative to fundamental improvements to Medicaid. In addition, these variously defined mid-level provider models mistakenly focus on restorative dental procedures, rather than the preventive services that must be our first priority if we are to eradicate the high levels of dental disease found in low-income populations. There are enough dentists to do that restorative work, and to do it cost-effectively, but there hasn't been a willingness in most states to pay dentists to do it.

Please do not be misled by rhetoric that there is, or will be, a shortage of dentists in the United States. For a period of time in the 1980s, some dental schools closed due to the then-prohibitive costs of operation. However, a number of new dental schools have opened in recent years and more are planned. If anything, we foresee a shortage of dental assistants and dental hygienists to perform necessary preventive care.

There are many barriers to access. Some are patient-related--such as lack of coverage, place of residence, travel costs, age of patient, cultural and language barriers, fear of dental treatment, special needs, and an inability to navigate the health care system. You may recall that the Congressional

The Honorable Elijah E. Cummings
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page 2

Research Service (CRS) identified these barriers in its report issued in conjunction with the subcommittee's hearing last month. Other barriers are provider-centric problems--such as inadequate economic support, administrative burdens and lack of workforce diversity.

Experience has taught us how to best address key provider-related barriers. As Dr. Grover indicated in her testimony, and which the California HealthCare Foundation report confirmed, states that invest in improving Medicaid fees, identifying and eliminating administrative burdens and engaging the dental community can create successful dental Medicaid programs. We highlighted Michigan's "Healthy Kids Dental" program, where dentists' participation shot up from 25 percent before the program began to its current level of 90 percent, cutting in half the time it takes a Medicaid recipient to travel to the dentist's office, and significantly increasing the number of children with a "dental home." There was no need for mid-level providers in these cases. The dentists responded in the states that made the investments.

The ADA-sponsored Community Dental Health Coordinator (CDHC) is not a mid-level provider. Rather, it is a cost-effective new dental team member focused on community outreach and system coordination. The CDHC will reach those who are unable to access the oral health delivery system, while delivering prevention services to individuals and supporting community-based prevention efforts to reduce the need for services. CDHC training will overcome the barriers addressed in the CRS report mentioned above. We are not aware of other programs that focus on this combination of functions at the present time.

The ADA believes that the burden remains with the proponents of the mid-level provider proposals to make the case to policymakers as to why they deserve public support. Testing a new dental provider is very costly and time consuming. The ADA has already spent \$2 million of its own funds to define, develop and test the CDHC program. Total cost of the CDHC pilot program will be about \$8 million. It would most likely cost a good deal more to pilot test a mid-level provider program. The CDHC requires just 15 to 18 months' training beyond high school, depending on the experience of the trainee. On the other hand, a proposed mid-level provider, such as the advanced dental hygiene practitioner (ADHP), requires a bachelor's degree and two years of training, coming within two years of the time commitment to become a dentist.

Prospective ADHPs would be subject to the same economic imperatives facing dentists who participate in Medicaid and SCHIP programs. History tells us they would be forced to make the same practical business decisions. For example, in 2000, New Mexico passed a law allowing hygienists to form collaborative partnerships with dentists. The collaborative arrangements were designed to allow hygienists to practice outside of the traditional dental office. As of 2008, only 37 of 800 hygienists had signed such agreements and there is no evidence that the New Mexico law has had a significant impact on underserved areas. In addition, for more than 20 years hygienists have had the option to practice independently in Colorado, but there is little or no difference between the fees charged for comparative services by independent hygienists and dentists in the state, demonstrating no cost savings to the public or private payers.

The ADA believes ADHP proponents have not made the case as to why taxpayers should underwrite the development of a costly new mid-level provider at a time when more dental schools are being opened, promising a great many more dentists who will be fully trained and licensed to perform *all* needed services.

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You asked in your letter about the term "dental home." This is an adaptation of the American Academy of Pediatrics' (AAP) definition of the "medical home" used to identify the primary care physician for children and the "supervisor" of the child's journey through the complicated medical care system. The ADA has developed a definition of a "dental home" that is family-centric and which reflects the differences between the medical and dental care systems. The ADA believes that this includes the relationship between the patient and the dental care provider and for the Association the "dental home" concept ensures optimal care for all dental patients, regardless of age.

We appreciate the importance of the entire health care team in promoting optimal oral health. We are committed to building and fostering collaborative activities to improve the oral health of all of America's children. Pediatric physicians are critical to this enterprise. At the same time, we firmly believe pediatricians and other physicians must have completed educational programs specific to oral health in order to provide the best oral health guidance and care to their patients.

We are in full agreement that pediatricians play a critical role in assisting children and their families to maintain optimal oral health and we actively collaborate with our pediatric physician colleagues and encourage them to do so. The ADA is committed to working with our physician colleagues as is demonstrated by the following actions:

- In 2005, the AAP received a multi-year Maternal and Child Health Bureau grant award, "Partnership to Reduce Oral Health Disparities in Early Childhood (PROHD)." Dr. Lindsey Robinson, Chair of the ADA Council on Access, Prevention and Interprofessional Relations (CAPIR), serves as the ADA's representative to the PROHD Advisory Committee. The goal of this effort is to improve child health professionals' skill in performing risk assessment and improving systems of care for the prevention of oral disease.
- In response to AAP's identification of oral health as a strategic priority for 2006-07, the ADA invited AAP officials to meet with ADA leadership. Leaders met on March 5, 2007 at AAP headquarters to discuss issues of mutual concern. The meeting was exceptionally cordial and fruitful and resulted in more than 24 action items for both organizations, including joint advocacy efforts in support of SCHIP expansion, collaboration to promote community water fluoridation, and joint promotion of the importance of oral health in relation to school readiness.
- In March, the American Dental Association Foundation (ADAF) awarded a three-year grant to AAP to help improve the oral health of children in critical age groups, particularly children under 3, who can develop dental problems before they see a dentist for the first time. The grant provides up to \$100,000 annually and will fund annual "train-the-trainer" oral health summits at which pediatricians will learn to conduct oral health risk assessments (including oral screening exams), teach families about oral health and prevention and refer children to a dental home. Over the course of the three-year span, all 66 AAP chapters will have the opportunity to send representatives who, in turn, will lead training in their home states. The grant also funds an oral health preceptorship program, which provides pediatricians in underserved areas with the support to promote oral health for vulnerable children.
- Oral health will be the focus of the pre-conference symposium at the AAP 2008 annual meeting, entitled Pediatrics in the 21st Century (PEDS 21), to be held in Boston in October 2008. *Oral Health in the 21st Century: Something to Smile About – Pediatrician's Role in Oral Health* will be offered as a free course to all attendees of the AAP National Conference & Exhibition. ADA has accepted an invitation to present opening greetings at the meeting.

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- The ADA is providing financial support for the upcoming AAP Children's Oral Health Summit, which will occur in Chicago in November.
- The 2007 ADA House of Delegates called for the convening of a 2009 Access to Care Summit, which will include a broad spectrum of stakeholders, in order to consolidate information about current events focused on improving access-to-care activities, develop a coordinated strategy for addressing access to oral health care challenges and establish metrics for activities related to the defined strategies. We have identified 12 stakeholder groups to participate in the summit, which will address the question: *What are we going to do, in the short and long term, both individually and collectively, to assure optimal oral health through prevention and treatment for underserved people?* The AAP has a representative on the planning committee for this summit.

We are pleased with these efforts but know much more needs to be done, particularly in the area of public education.

Unfortunately, there are many adults who still believe that because a child's primary teeth will eventually fall out there is no urgency about a child's oral health. As you noted, this is indeed a "dangerous line of thinking" that can result in a lifetime of dental disease. Although pediatric physicians can play a critical role in providing anticipatory guidance to parents concerning how to maintain a child's teeth, it is unrealistic to expect our physician colleagues to have the time necessary to provide appropriate oral health education to their patients.

Families need to understand that a child's oral health is integral to his or her ability to grow, thrive, learn, speak and be healthy. How we educate, communicate and motivate parents and caregivers to take the appropriate actions to assure a child has optimal oral health is the key question: What are the messages and how should they be delivered? How do we best reach communities at highest risk for oral disease?

We need a comprehensive national prevention and awareness campaign. This will require significant federal investment. This is not something that either medicine or dentistry can address on their own; it must be supplemented by sustained public health and social marketing efforts, such as the Sesame Workshop's "Call to Action on Oral Health." We must empower children and their families to make healthy choices. We must provide parents with strategies to help their children adopt healthy behaviors. These efforts must be culturally and linguistically appropriate and cannot be accomplished solely within the confines of either a pediatric physician's office or a dentist's office, but rather must come from the community and be directed to the community.

In response to the last issue raised in your letter, let me state how pleased I am to hear that you had an opportunity to participate in the Baltimore Give Kids A Smile program this year. ADA's members are delighted with this program, and each year more dentists step forward to volunteer.

This year the program had about 40,000 volunteers, including about 12,000 dentists, who delivered care to approximately one-half million children. In response to your question regarding the expansion of our Give Kids A Smile (GKAS) program, the ADA Board of Trustees adopted a resolution in December 2006 in favor of making the program "more than just a day." They would like it to be a year-round initiative. As part of that initiative, the ADA formed a National Advisory Board to find ways of stimulating collaboration and building coalitions to address children's unmet oral health care needs. The advisory board will also implement an expanded fundraising program to provide financial and

The Honorable Elijah E. Cummings
October 8, 2008
page 5

technical assistance to new and existing community-based local and regional GKAS programs, and will enable the ADA and others to effectively advocate for better access to oral health care for all children.

To date, several highlights of our expansion efforts have included two successful GKAS Promising Practices Symposiums, the announcement of our first four GKAS Program Champions, a GKAS grant program, the first annual GKAS Awards Gala that raised almost \$300,000 for access-to-care grants, and a growing GKAS Fund. The GKAS National Advisory Board is in the midst of strategic planning and has numerous exciting goals for continued expansion efforts. At the same time, please let me caution you that volunteerism is not a substitute for an effective health-care system.

In sum, Congressman Cummings, I wish to thank you for your interest and efforts to improve oral health care for the underserved populations in our nation.

We look forward to working with you and your staff in the future.

Sincerely,

A handwritten signature in black ink that reads "Mark J. Feldman DMD". The signature is written in a cursive, flowing style.

Mark J. Feldman, D.M.D.
President

MJF:TS:nh