MEDICAID'S EFFORTS TO REFORM SINCE THE PREVENTABLE DEATH OF DEAMONTE DRIVER: A PROGRESS REPORT

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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MEDICAID'S EFFORTS TO REFORM SINCE THE PREVENTABLE DEATH OF DEAMONTE DRIVER: A PROGRESS REPORT

WEDNESDAY, OCTOBER 7, 2009

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

The subcommittee met, pursuant to notice, at 2:40 p.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Watson, and Jordan.

Staff present: Jaron R. Bourke, staff director; Tom Mulloy, Office of Representative Kucinich; Jean Gosa, clerk; Charisma Williams, staff assistant; Carla Hultberg, chief clerk, full committee; Leneal Scott, IT specialist, full committee; Adam Hodge, deputy press secretary, full committee; Ashley Callen, minority counsel; Molly Boyl, minority professional staff member; and Adam Fromm, minority parliamentarian/Member services coordinator.

Mr. KUCINICH. The Domestic Policy Subcommittee of Oversight and Government Reform will now come to order.

I want to thank the witnesses and those in the audience and my colleague, Ranking Member Jordan, for your patience. The House had in consideration a bill that I was the author of, and so I had to be there to present it. It's good to be here with you as we start this hearing.

This hearing is going to be the fourth in a series on access to pediatric dental services in Medicaid. The subcommittee has focused on this issue since the death of Deamonte Driver in February 2007; and that's Deamonte Driver's picture. His death highlighted the inadequacy of dental services for Medicaid and rural children in Maryland.

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 5 legislative days to submit a written statement or extraneous materials for the record.

On February 25, 2007, Deamonte Driver, a 12-year-old boy from Prince George's County, Maryland, died from a brain infection caused by untreated tooth decay. Deamonte's tragic death could

have been easily prevented by access to dental care, dental care he was entitled to and should have received through United HealthCare, Maryland's Medicaid dental provider.

Unfortunately, that company failed to meet its obligation to provide beneficiaries with access to dental providers. So onerous were the administrative barriers that United HealthCare had created, "it took one mother, one lawyer, one online help supervisor, and three case management professionals to make a dental appointment for one Medicaid child," according to testimony we received from Laurie Norris, a legal advocate who worked with the Driver family.

In the 2½ years since Deamonte's preventable death, this subcommittee has been conducting an inquiry into the adequacy of efforts on a State level to ensure access to pediatric dental services under Medicaid, as well as the actions that the Center for Medicaid and State Operations, CMS, to conduct oversight of State systems.

At our first hearing in May 2007, we learned that Deamonte Driver was not the only Maryland youth who wasn't receiving dental care to which he was entitled by Medicaid. In fact, our investigation of United HealthCare found that approximately 11,000 Maryland children in United HealthCare's Medicaid operation had not seen a dentist in at least 4 years. We found that United HealthCare provided information to Medicaid beneficiaries that was so inaccurate and outdated it would have been virtually impossible to find a dental care provider.

We also learned that CMS did virtually nothing to address the problems in poorly performing State systems. Dennis Smith, director of CMS at the time, argued that financial sanctions are the only tool CMS has to enforce compliance; and he was unwilling to hand down financial sanctions because he said the cost was ultimately borne by the patient.

Simply put, this is not the case; and in a letter to Mr. Smith the subcommittee outlined nine actions that CMS could take that would serve to enforce the statutory responsibilities that States have to ensure that Medicaid-eligible children have access to dental services.

Our second hearing focused on CMS's response to this letter and actions taken by them in the years since Deamonte Driver's death to address the deficiencies in its oversight responsibilities. While they did take some action, their efforts, unfortunately, fell short of effecting any real change. In fact, the hearing revealed that most of the progress of the State of Maryland was made despite CMS, that the agency was not actively involved in the State's efforts and provided almost no guidance.

Additionally, CMS continued to neglect the issue of provider reimbursement rates, despite hearing testimony about the importance of them to effecting system-wide reform. Astoundingly, Mr. Smith even acknowledged as such during our first hearing, but stubbornly, stubbornly continued to avoid the issue. Mr. Smith resigned from his post not long after our second hearing.

After that, things began to change. A GAO report, the first of its kind since 2000, revealed that millions of Medicaid-enrolled children suffer from tooth decay, almost one-third of the total Medicaid

population. Medicaid children are roughly twice as likely as privately insured children to suffer from tooth decay.

Moreover, this pattern has persisted for years. Very little has been done to improve access to and utilization of dental services. In a sense, the problem of tooth decay is getting worse, because the rate of decay in the teeth of children aged 2 to 5 has increased in recent years.

Now our third hearing on the issue demonstrated that improvement is possible. Under new leadership and continued congressional scrutiny, CMS began to turn a corner. The interim director of the Center for Medicaid and State Operations outlined a number of actions that they had taken to engages States actively in reform as well as to improve their own oversight functions. They conducted 17 reviews of State systems with utilization rates below 30 percent and provided each State with its own report and recommendations, worked with States to develop oral health schedules that met Federal guidelines, and formed an Oral Health Technical Advisory Group with State Medicaid directors.

We also learned that the State of Maryland, where this whole journey began, continued making considerable progress. The dental action committee that they formed developed seven recommendations to improve access to dental care for Maryland's children. Two ended up in a budget submitted by Martin O'Malley, the Governor of Maryland, and another was passed by the State legislature.

Today, the GAO will share the findings of their most recent report, commissioned at the request of myself and Mr. Cummings, on the adequacy of pediatric dental oversight at the State and Federal level. I am thankful to GAO for their hard work and dedication in studying this problem.

We will also hear, for the first time, from the new director of the Center of Medicaid and State Operations. I am looking forward to their report on the progress they have made and how they plan to use that momentum to address the gaps that remain as identified in the GAO report.

Additionally, we are going to hear from State Medicaid officials and researchers who have studied and implemented successful initiatives to increase access to and utilization of dental services, as well as to improve provider participation.

I believe and hope that CMS has turned a corner in their oversight of pediatric dental services since the death of Deamonte Driver. But the magnitude of the underlying problem is great, and even today there are millions of children just like Deamonte entitled to dental care but not receiving it. The urgent job of everyone here today is to move quickly to prevent another one of them from dying from preventable dental disease.

Finally, I just want to share with my colleagues, you know, people ask me when Deamonte's death was first announced, why are you so interested? It's just 1 person out of 300 million. You know, these things happen.

I remember growing up in the inner city. I was the oldest of seven. My parents never owned a home and lived in 21 different places by the time I was 17, including a couple of cars. And one of the things we didn't have was dental care. I mean, I can remember chewing on gum balls and having them just breaking off—my

teeth breaking off into the gum balls. And I can remember having dental problems that didn't get treated for a long, long time.

And I don't want to get too graphic about it, but for those who have experienced being a child without access to dental care, you know what a nightmare it can be.

Deamonte Driver, that's me. That's me as a young boy. His life was sacrificed to an uncaring system. We can't have any more Deamonte Drivers out there.

Look at his face. I mean, he is just—he is really asking us, what we are going to do about this? Are we going to take a stand to make sure that the children of America get the dental services that they are entitled to?

That's the challenge we have, and I will not rest. I know there are colleagues like Mr. Cummings and Mr. Jordan, we have very powerful feelings about this as well.

But I will not rest until we have caused the death of Deamonte Driver to be a driver of a new day in delivering dental services to the children of this country and particularly those who are served by Medicaid.

I want to thank you for your indulgence, Mr. Jordan.

With that, I yield to the ranking member of this committee, Mr. Jordan, for his opening statement.

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

Opening Statement
Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee
Medicaid's Efforts to Reform since the Preventable Death of Deamonte Driver:
A Progress Report
October 7, 2009

On February 25, 2007 Deamonte Driver, a twelve-year-old boy from Prince George's County, Maryland, died from a brain infection caused by untreated tooth decay. Deamonte's tragic death could have been easily prevented by access to dental care--dental care he was entitled to and should have received through United HealthCare, Maryland's Medicaid dental provider. Unfortunately, that company failed to meet its obligation to provide beneficiaries with access to dental providers. So onerous were the administrative barriers United HealthCare had created, "it took one mother, one lawyer, one online help supervisor, and three case management professionals to make a dental appointment for one Medicaid child," according to testimony we received from Laurie Norris, a legal advocate who worked with the Driver family.

In the two and a half years since Deamonte's preventable death, this Subcommittee has been conducting an inquiry into the adequacy of efforts on the state level to ensure access to pediatric dental services under Medicaid, as well as the actions the Center for Medicaid and State Operations, CMS, to conduct oversight of state systems.

At our first hearing in May 2007, we learned that Deamonte Driver was not the only Maryland youth who wasn't receiving dental care to which he was entitled by Medicaid. In fact, our investigation of United HealthCare found that approximately 11,000 Maryland children, in United HealthCare's Medicaid operation, had not seen a dentist in at least four years. We found that United HealthCare provided information to Medicaid beneficiaries that was so inaccurate and outdated, it would have been virtually impossible to find a dental care provider.

We also learned CMS did virtually nothing to address the problems in poorly performing state systems. Dennis Smith, director of CMS at the time, argued that financial sanctions are the only tool CMS has to enforce compliance, and that he was unwilling to hand down financial sanctions because that cost was ultimately borne by the patient.

Simply put, this is not the case, and in a letter to Mr. Smith the Subcommittee outlined nine actions that CMS could take that would serve to enforce the statutory responsibilities that states have to ensure Medicaid-eligible children have access to dental services.

Our second hearing focused on CMS's response to this letter and actions taken by them in the year since Deamonte's death to address the deficiencies in its oversight responsibilities. While they did take some action, their efforts unfortunately fell short of effecting any real change. In fact, the hearing revealed that most of the progress that the state of Maryland made was despite CMS-- the agency was not actively involved in the state's efforts, and provided almost no guidance.

Additionally, CMS continued to neglect the issue of provider reimbursement rates, despite hearing testimony about the importance of them to effecting system-wide reform. Astoundingly, Mr. Smith even acknowledged as such at our first hearing, but stubbornly continued to avoid the issue. Mr. Smith resigned from his post not long after our second hearing.

After that, things began to change. A GAO report, the first of its kind since 2000, revealed that millions of Medicaid-enrolled children suffer from tooth decay--almost one-third of the total Medicaid population. Medicaid children are roughly twice as likely as privately-insured children to suffer from tooth decay. Moreover, this pattern has persisted for years; very little had been done to improve access to and utilization of dental services. In a sense, the problem of tooth decay is getting worse because the rate of decay in the teeth of children aged two through five has increased in recent years.

Our third hearing on the issue demonstrated that improvement is possible. Under new leadership and continued Congressional scrutiny, CMS began to turn a corner. The interim director of the Center for Medicaid and State Operations outlined a number of actions that they had taken to engage states actively in reform as well as improve their own oversight functions. They conducted 17 reviews of state systems with utilization rates below 30% and provided each state with its own report and recommendations; worked with states to develop oral health schedules that met federal guidelines; and formed an Oral Health Technical Advisory Group with state Medicaid directors.

We also learned that the state of Maryland, where this whole journey began, continued making considerable progress. The Dental Action Committee that they formed developed seven recommendations to improve access to dental care for Maryland's children; two ended up in the budget submitted by Martin O'Malley--the new governor of Maryland--and another was passed by the state legislature.

Today, GAO will share the findings of their most recent report, commissioned at the request of myself and Mr. Cummings, on the adequacy of pediatric dental oversight at the state and federal level. I am very thankful to the GAO for their hard work and dedication in studying this problem. We will also hear, for the first time, from the new director of the Center of Medicaid and State Operations. I am looking forward to their report on the progress they have made and how they plan to use that momentum to address the gaps that remain as identified in the GAO report.

Additionally, we will hear from state Medicaid officials and researchers who have studied and implemented successful initiatives to increase access to and utilization of dental services, as well as improve provider participation.

I believe that CMS has turned a corner in their oversight of pediatric dental services since the death of Deamonte Driver. But the magnitude of the underlying problem is great, and even today, there are millions of children just like Deamonte--entitled to dental care, but not receiving it. The urgent job of everyone here today is to move quickly to prevent another one of them from dying from preventable dental disease.

Mr. JORDAN. I thank the chairman for his work and for calling this hearing as well and for continuing to highlight the importance of access to dental care for children. I look forward to hearing from our witnesses about what has been done to enhance pediatric dental services and improve access, since these issues were first looked at by the subcommittee following the tragic death of Deamonte Driver in 2007.

Barriers to care, including low reimbursement rates for dentists, lack of understanding of the importance of our oral health, and excessive administrative burdens for patients and providers all contribute to the problem. According to the report the GAO released today, State Medicaid programs have taken steps toward improving access, but gaps remain that must be addressed.

Likewise, CMS has worked to improve its oversight of pediatric dental issues in Medicaid. More progress certainly is necessary. In 2008, GAO estimated that one in three children on Medicaid had untreated tooth decay. I hope our witnesses today will tell us what is being done to fill these gaps and treat these children.

Unfortunately, the issue of access to care is not unique to pediatric dentistry for Medicaid enrollees but a problem across the health care spectrum. The problems of access to care are prevalent in our existing government-run programs, including Medicaid, Medicare, and SCHIP. Low reimbursement rates set at the State level for Medicaid and the national level for Medicare lead to a low participation of providers in these programs. In this respect, the terrible story of Mr. Driver can prove to be a lesson as we move through health care reform and evaluate the different options for ensuring a healthy America.

With that, Mr. Chairman, I yield back the balance of my time.

Mr. KUCINICH. I thank my colleague from Ohio; and the Chair recognizes Mr. Cummings from Maryland, who has been working on this issue from the time that it was first known. I want to thank him for his dedication.

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

I really do thank you for your interest in this issue, and I thank you—as I listened to you just a moment ago, I am reminded that what you have done is you have taken some of your experiences in life as a child and turned them around and used them as a passport to help others, and that says a lot. So often people want to bury what happened in their past. However, you take it and you raise it up to remind us that this could happen to anybody. So I do—but not only do you do that, you then lay out a mission to correct it. So I really do appreciate you doing this.

You know, Deamonte died on February 25, 2007, and I know that the chairman has already talked about it, but I think about it every day, just about. And when I think about an untreated tooth and an infection spreading to a child's brain, $80 worth of dental care might have saved his life, but Deamonte was born, he never made it to the dental chair.

Mr. Chairman, you recall we first held a hearing on this topic at my request back on May 2, 2007, in an effort to identify the critical breakdowns in our Medicaid system's provision of dental care to children. As our dental health professionals here today know, oral health is an often overlooked but vital component of health care.

Preventive dental care, especially for our children, is a fundamental need for their healthy development into adulthood.

In fact, tooth decay is the most common childhood disease. It is five times as common as asthma and seven times as common as hay fever. This has the most detrimental impact on low-income communities. Eighty percent of cavities occur in only 25 percent of children, predominantly low-income children. Low-income children suffer twice as much from tooth decay as do more affluent children. Millions of school hours are lost each year to dental-related illness. Poor children suffer nearly 12 times more restricted activity days than children from more affluent families due to dental-related illness.

Our previous hearings on this matter revealed woeful failures of the Centers for Medicaid & Medicare Services and its State partners to comply with section 1905(r)(3) of the Social Security Act, which ensures that every child—every Medicaid-eligible child will have access to medically necessary dental care under the Early Periodical Screening, Diagnostic, and Treatment [EPSDT], provision. We found that Medicaid fell glaringly short of meeting this mandate and was given directives to address these disparities. I am eager to hear today about efforts that they have partaken in to address the disparities.

Since Deamonte's death, my home State of Maryland has resolved to do everything possible to prevent such an avoidable tragic loss; and we have made significant gains to improve children's access to dental care. In just 2 years, Mr. Chairman, 41,000 more children in Maryland received Medicaid-funded dental service than those who received such service in 2007. In 2009 alone, Maryland is making an overall $81½ million investment in Medicaid dental care services Statewide.

Governor Martin O'Malley, to his credit, also convened a dental action committee which developed seven recommendations to better serve our children, including raising reimbursement rates for dental services, initiating a single State-wide vendor for dental services, spending $2 million per year to enhance the dental health infrastructure, providing dental screenings for children, creating a new dental hygienist position, improving education for dental students, and crafting a public education campaign on oral health. The Governor included the first three items in his 2000 budget, and he is currently working with a dental action committee to implement the others.

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

As I close, the company is now working to develop a similar partnership with Howard University that will reach across the Maryland border to Deamonte's home county, Prince George's.

All of these actions are commendable. However, they are being implemented solely on a State level. In order for us to see monu-

mental gains, changes must be made Nationwide. We have been anticipating a review of CMS's since our last hearing to learn what has been accomplished at the Federal level. We were sorely disappointed regarding the lack of demonstrable effort between our first and second hearings, so GAO's report has been eagerly awaited. I am hopeful that we are turning the page to a new day.

With the leadership of Ms. Cindy Mann, CMS will work to create innovative reforms to address the concerns raised in GAO's report, and these reforms will incorporate the effective and efficient programs that are already working on a State level.

Mr. Chairman, a child died because of our failure as adults, of our failure as adults to discharge this mandate. For Deamonte Driver and for every child and adult like him, we must proceed with a sense of great urgency and with an unfailing determination to see our efforts to completion. It is their turn. It is their turn to grow up. It is their turn to be healthy children. It is their turn to deliver and develop the gifts that they have been given to deliver to us. But if they are not healthy and if their teeth are rotting and if we are not doing anything about it, shame on us.

Thank you very much, Mr. Chairman. With that, I yield back.

Mr. KUCINICH. Thank you, Mr. Cummings, for your commitment, your statement, your heart, your passion, and your willingness to take a stand.

We are now going to go to the witnesses. There are no additional opening statements. The subcommittee will receive testimony from the witnesses before us today.

I would like to start by introducing our first panel:

Ms. Katherine Iritani is Acting Director for Health Issues at the U.S. Government Accountability Office. In her 27-year career with GAO, she has helped plan and execute a wide variety of program and evaluation assignments. In recent years, she has overseen multiple evaluative studies on Medicare financing and access issues, including children's access to preventive and dental services. Ms. Iritani currently works in GAO's Seattle field office and has a business administration degree from the University of Washington.

Next, Ms. Cynthia Mann. Ms. Mann was appointed director of the Center for Medicaid and State Operations [CMSO], in June 2009, where she is responsible for the development and implementation of national policies governing Medicaid, the State Children's Health Insurance Program, survey and certification, Medicaid Integrity Program, and the Clinical Laboratories Improvement Amendments. CMSO, the Center for Medicaid and State Operations, also serves as the focal point for all CMS interactions with States and local governments.

Prior to her return to CMS in 2009, Ms. Mann served as a research professor at Georgetown University Health Policy Institute and executive director of the Center for Children and Families at the Institute. Her work at Georgetown focused on health coverage, financing, and access issues affecting low-income populations. Previously, she served as director of the Family and Children's Health Programs at CMSO from 1999 to 2001, where she played a key role in implementing Medicaid and the SCHIP program.

Before joining the government in 1999, Ms. Mann led the Center on Budget and Policy Priorities, Federal and State health policy

work. She also has extensive State-level experience, having worked on health care welfare and public finance issues in Massachusetts, Rhode Island, and New York.

Thank you both for appearing before this subcommittee today.

It's the policy of the Committee on Oversight and Government Reform to swear in our witnesses before they testify. I would ask that you rise.

[Witnesses sworn.]

Mr. KUCINICH. Let the record reflect that each witness answered in the affirmative.

I would ask that each of the witnesses now give a brief summary of your testimony. I ask that you keep this summary under 5 minutes in duration. Your complete written statements are going to be in the record; and that's what we are here to do, to have you amplify on that in your time that you will be presenting.

So I would like you, Ms. Iritani, to be our first witness. You may begin.

STATEMENTS OF KATHERINE IRITANI, ASSISTANT DIRECTOR, HEALTH ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND CINDY MANN, DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS

STATEMENT OF KATHERINE IRITANI

Ms. IRITANI. Mr. Chairman, Ranking Member Jordan, and members of the subcommittee, I am pleased to be here to discuss children's access to Medicaid dental services, a longstanding concern.

As you noted in your opening remarks, an estimated one of every three children in Medicaid has untreated tooth decay. One in nine have it in three or more teeth. This is about twice the rate experienced by privately insured children and translates to millions of Medicaid children in need of dental care. In too many cases, this need is urgent.

My statement is based on GAO's report that you are releasing today. This report summarizes at a national level efforts of States and CMS to improve Medicaid dental services for children. In summary, we found that State Medicaid programs and CMS have taken a number of actions to monitor and improve children's access to dental services, but problems with access persist and gaps in CMS oversight remain.

First, let me share highlights of States' actions from our Web-based survey of State Medicaid programs. All States reported monitoring children's access to dental services, and nearly all States had implemented one or more initiatives to improve access through actions to reach out to families such as establishing hotlines to help them find a dentist and initiatives such as raising reimbursement rates to encourage more dentists to serve Medicaid children.

Nonetheless, States reported multiple barriers to improving access. These barriers are well-known and longstanding, for example, for families finding a dentist to treat their children; for providers, concerns remain about families missing their appointments, low reimbursement rates and administrative burdens. These barriers persist, despite States actions to address them.

Of significance, most States indicated their initiatives to improve access had not met their expectations; and two-thirds of the 21 States that reported contracting with managed care organizations to provide dental services said those organizations were not meeting the States' access standards.

The bottom line, children's access to Medicaid dental services has been improving but remains low. States report that only about 35 percent of Medicaid children nationally received any dental service in 2007, as compared to HHS's goal of 66 percent of low-income children receiving a preventive dental service by 2010.

Now let's turn to actions of CMS. CMS has improved its oversight of State programs in several ways, but more can be done.

Two observations: First, CMS has focused dental reviews of 17 States with low dental access rates, identified significant problems, including concerns in eight States that managed care organizations had inadequate numbers of dentists in their networks. CMS did not, though, require corrective action plans of States or have plans to review other States with low dental access rates.

Second, CMS has improved its guidance to and communications with States. For example, CMS posted descriptions of four States promising practices for improving access on its Web site, but nearly every State, 49 in all, reported to us that they need more from CMS. States reported, for example, that they need specific guidance in areas such as establishing appropriate dental payment rates and improving billing policies.

Notably, when we ask States how CMS could help them, most States answered that CMS should provide more information on what was working in other States. Twenty-six States reported to us that they believe their State had one or more best practices for delivering dental services that could be shared with others.

In conclusion, CMS and States have taken noteworthy steps to improve children's access to Medicaid dental services. Concerted and continued efforts and, in these challenging fiscal times, innovative solutions will be needed to address the multiple and longstanding barriers to improving children's oral health. For its part, CMS can help through ongoing assessment, guidance, and support of States' efforts, building upon the steps the agency has recently undertaken. We have made several recommendations to CMS toward this end and have ongoing work for the Congress further examining these issues.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

Mr. KUCINICH. I thank the gentlewoman.

[The prepared statement of Ms. Iritani follows:]

United States Government Accountability Office

GAO

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

For Release on Delivery
Expected at 2:00 p.m. EDT
Wednesday, October 7, 2009

MEDICAID

State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but More Can Be Done

Statement of Katherine M. Iritani
Acting Director, Health Care

GAO-10-112T

Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today as you examine federal and state efforts to improve access to dental services by children in Medicaid (a joint federal and state program that provides health care coverage, including dental care, for low-income children). Dental disease remains a significant problem for children in Medicaid. Although dental services are a mandatory benefit for the 30 million children served by Medicaid,[1] these children often experience elevated levels of dental problems and have difficulty finding dentists to treat them. In testimony before your Subcommittee last September, we reported that children in Medicaid were almost twice as likely to have untreated cavities as children with private insurance and that the percentage of children in Medicaid who received any dental care was far below the Department of Health and Human Service's (HHS) target for low-income children.[2] Concerns about low-income children's poor oral health, inadequate access to dental services, low payment rates for dental services, and insufficient federal and state efforts to address oral health access problems are long-standing. During subcommittee hearings in May 2007 and February 2008, you raised concerns about the effectiveness of federal oversight of state Medicaid dental services by the Centers for Medicare & Medicaid Services (CMS), the agency that oversees Medicaid at the federal level.

My remarks today are based on our report, released at this hearing, *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain.*[3] This report was prepared at the request of the subcommittee and examined (1) state strategies to monitor and improve access to dental care for children in Medicaid and (2) CMS actions since 2007 to improve oversight of Medicaid dental services for children. To identify state strategies to monitor and improve children's access to Medicaid dental services, we conducted a Web-based survey of state Medicaid directors in all 50 states and the

[1]Low-income children eligible under a state Medicaid plan generally are entitled to coverage of screening, diagnostic, and treatment services—including dental services—under Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit.

[2]GAO, *Medicaid: Extent of Dental Disease in Children Has Not Decreased*, GAO-08-1176T (Washington, D.C.: Sept. 23, 2008).

[3]GAO, *Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain*, GAO-09-723 (Washington, D.C.: Sept. 30, 2009).

District of Columbia (we refer to the District of Columbia as a state in this report)—all 51 responded to our survey. The survey included questions on the methods states have used for promoting and monitoring dental utilization, statewide goals for the delivery of dental services, and the federal support provided to states for the provision of Medicaid dental services. We also reviewed contracts between state Medicaid programs and nine large managed care organizations (MCO) to identify certain dental provisions concerning network adequacy and access standards.[4] To examine CMS's oversight of state Medicaid dental services for children, we interviewed CMS officials, dental associations, and key stakeholders; reviewed federal laws, regulations, and CMS guidance; and analyzed data used by CMS to monitor provision of Medicaid dental services. Our work was performed in accordance with generally accepted government auditing standards.

State Medicaid Programs Reported They Employ Multiple Strategies to Monitor and Improve Access to Medicaid Dental Services, but Problems Persist

All 51 states responding to our survey reported that they monitor the provision of dental care to Medicaid-enrolled children—often using three or more methods. Common methods included collecting utilization data, conducting surveys of oral health, and monitoring dental claims.[5] States also reported using various measures to assess children's access to Medicaid dental services, including the percentage of children who had a dental visit in the previous year, the percentage of children who had not visited a dentist in the last 3 years, and the percentage of dentists in the state who treat children in Medicaid. Forty-two states also reported that they have set at least one statewide dental utilization goal related to the provision of children's dental care in Medicaid. Commonly reported goals include the percentage of children receiving any dental care in a given period exceeding a certain threshold, the ratio of participating dental providers to Medicaid children exceeding a certain threshold, and the percentage of children who report difficulty finding dental care fall below a certain threshold.

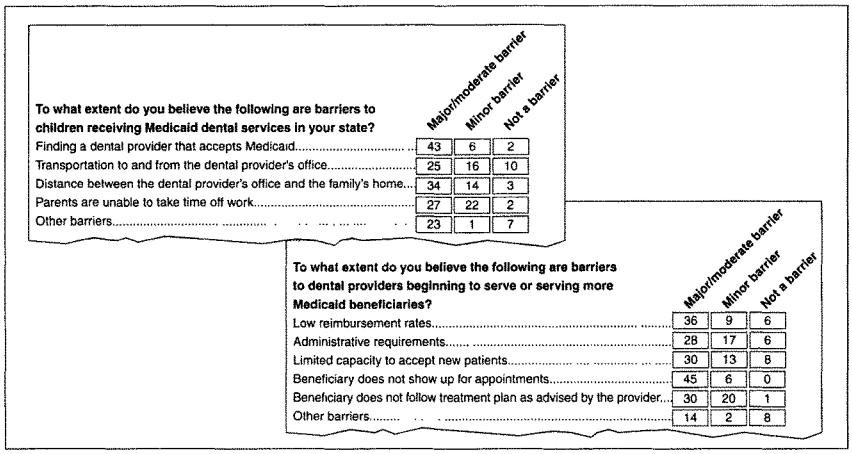
[4]We obtained a non-generalizable sample of contracts from MCOs that covered dental services and that served the most Medicaid beneficiaries in nine states, including five states whose dental programs had been reviewed by CMS in 2008.

[5]States are required to report annually to CMS on the provision of EPSDT services, including dental services. The annual EPSDT participation report, Form CMS-416, is the agency's primary tool for gathering data on the provision of dental services to children in state Medicaid programs.

States' oversight of MCO provider networks varied. All 21 states that provide Medicaid dental services through MCOs reported that they set measurable access standards for MCOs, but more than half also reported that MCOs in their state do not meet any, or only meet some, of the state's dental access standards. Common MCO access standards include maximum waiting times for appointments, maximum travel time or distance to the dentist's office, and minimum provider-to-patient ratios. Twelve of the 21 states reported that they routinely verify that MCO providers accept new Medicaid patients. Two states did not report taking any action to verify MCO provider networks. Although 17 states reported that they used incentives or penalties to encourage the MCOs to meet or exceed state standards, potential incentives or penalties did not always produce the desired result. For example, one state reported MCOs had not met any of the established standards even though MCOs could be paid a bonus if they met some or all of the standards. Similarly, other states reported that only some standards were being met, despite potential financial penalties for MCOs that did not meet all of the state's standards. Our review of nine MCO contracts illustrates variations in the standards that states established for MCOs concerning network adequacy and access measures. For example, some, but not all, contracts specified a maximum number of Medicaid enrollees per dental provider—one contract specified a county-level maximum of 486 enrollees per dental provider, while other contracts did not specify such a maximum.

Nearly all states reported that they had undertaken initiatives to improve children's access to Medicaid dental services, but persistent barriers remain. For example, states reported simplifying claims processing, increasing reimbursement rates, recruiting providers, and educating beneficiaries. Although some states reported limited success, Medicaid dental utilization rates remain low. CMS data show that the national average Medicaid dental utilization rate for children had improved from 27 percent in 2000 to 35 percent in 2007—but in 2007, only 1 state reported a dental utilization rate above 50 percent and 12 states remained below 30 percent. Forty-eight states reported that the principal barriers that contributed to the low use of dental services by Medicaid beneficiaries in 2000—including low provider participation rates, administrative burdens, and insufficient funding—were impeding their current efforts. States also reported that access rates could be affected by barriers faced by children seeking dental services, such as finding a provider that accepts Medicaid, and barriers faced by providers serving Medicaid beneficiaries, such as beneficiaries not showing up for appointments (see fig. 1).

Figure 1: Barriers to Children Seeking Medicaid Dental Services and Barriers to Dental Providers Serving Medicaid Beneficiaries, as Reported by State Medicaid Programs



Source: GAO (Survey of state Medicaid directors conducted between December 2008 and January 2009)

CMS Has Taken Action to Improve Federal Oversight of State Medicaid Dental Services for Children, but Gaps Remain

Responding to concerns expressed by your subcommittee about CMS oversight of state Medicaid dental services, CMS has taken a number of actions since May 2007 to strengthen its oversight of Medicaid dental services for children, but gaps remain in the agency's efforts. CMS actions include the following:[6]

- **Focused dental reviews in 17 states identified significant concerns, but CMS did not plan additional reviews.**[7] Between October 2007 and May 2008, CMS conducted a series of focused dental reviews in 17 states.[8] CMS identified concerns in all 17 states it reviewed, including multiple findings in some states, and made recommendations to all states. In 11 states, CMS reported concerns that the states were not adhering to federal law or regulations. CMS also identified several promising practices to improve the delivery of oral health services, which it highlighted in its summary report.[9] Although CMS reviews identified shortcomings in state practices and identified needed improvements, CMS did not have plans at the time of our review to conduct focused dental reviews in additional states. CMS 416 data from 2006 showed that 24 of the 34 states that CMS did not review reported dental utilization rates between 31 and 40 percent of eligible children having received any dental service in the prior year—well below HHS's Healthy People 2010 goal of having 66 percent of low-

[6]See GAO-09-723 for additional information on the actions taken by CMS to improve its oversight of Medicaid dental services.

[7]CMS focused reviews were designed to examine state efforts to improve children's dental utilization rates, assess state compliance with federal Medicaid statutes and regulations, and identify promising or notable state practices to improve the delivery of oral health services.

[8]Fifteen of the 17 states reviewed had reported dental utilization rates below 30 percent in fiscal year 2006: Arkansas, California, Delaware, District of Columbia, Florida, Louisiana, Michigan, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Pennsylvania, and Wisconsin. In addition, Maryland was reviewed in October 2007 and Georgia was reviewed in May 2008 at the request of the subcommittee.

[9]CMS, *2008 National Dental Summary*, (January 2009) and *Final Report on Maryland's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program With a Focus on Dental Services for Children* (Feb. 5, 2008).

income children under age 19 receive a preventive dental service.[10] In addition, CMS did not require corrective action in states found to have inadequate MCO networks. CMS's focused dental reviews identified eight states that provided dental services through managed care that did not ensure that MCO provider networks were adequate to afford access to covered dental services. CMS made recommendations to strengthen MCO provider networks in all eight states; however, CMS did not require these states to take corrective action—rather, agency officials indicated they would follow up with states on the status of CMS's recommendations.

- **CMS established an Oral Health Technical Advisory Group and published a dental policy document, but states reported additional guidance was needed.** In conjunction with the National Association of State Medicaid Directors, CMS established an Oral Health Technical Advisory Group to address issues related to oral health services. Advisory group projects include examining the effects of recent legislation on oral health programs, considering improvements to the CMS 416 annual reports, and improving materials used to inform beneficiaries of their Medicaid dental benefits. In addition, CMS posted a 16-page document on Medicaid dental policy issues on its Web site in September 2008. This document covered a variety of questions from states on topics including periodicity schedules, dental referral requirements, covered services, and patient cost sharing.[11] Although CMS has taken action to provide some guidance to states, states report that additional guidance from CMS is needed. In response to our survey, nearly all states reported that additional CMS guidance could help them improve delivery of Medicaid dental services. States cited a need for additional information in several areas, including information on billing policies, establishing appropriate dental fee schedules, improving documentation and coding practices, and information on quality and preventive initiatives.

[10]Recognizing the importance of good oral health, HHS in 1990 established oral health goals as part of its Healthy People 2000 initiative; and in 2000 updated these oral health goals for 2010. These include goals related to oral health in children, for example, reducing the proportion of children with untreated tooth decay. Another goal 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 each year to 66 percent in 2010. See U.S. Department of Health and Human Services, Public Health Service, *Progress Review: Oral Health* (Feb. 7, 2008).

[11]HHS, Centers for Medicare & Medicaid Services, *Policy Issues in the Delivery of Dental Services to Medicaid Children and Their Families* (Sept. 22, 2008); http://www.cms.hhs.gov/medicaiddentalcoverage/ (accessed Oct. 6, 2008)

- **CMS has taken steps to improve communications with states and stakeholders, including sharing promising state dental practices, but states reported further collaboration was needed.** From 2007 through 2009, CMS held several meetings and conference calls with state dental representatives, provider associations, and other stakeholders to discuss issues concerning Medicaid dental services for children. Groups involved in CMS partnership activities included American Academy of Pediatric Dentistry, the American Association of Public Health Dentistry, the Association of State and Territorial Dental Directors, and the American Dental Association. CMS also posted "promising practices"—described by CMS as successful state programs that reflect innovative approaches to meeting common problems—on its Web site. As of May 2009, CMS had posted promising dental practices from Delaware, South Carolina, Tennessee, and Virginia. Although CMS has taken action to involve stakeholders and share promising dental practices, 37 states responding to our survey indicated a need for more information on other states' efforts to improve dental utilization. Eleven states reported that they were unaware of the promising practices posted on CMS's Web site and 26 states responding to our survey reported that their states had best practices that could be shared with other states, such as providing mobile dental vans, training and reimbursing physicians to do oral screens and apply fluoride varnish, and establishing a dental home for children.

In conclusion, states and CMS have made concerted efforts to improve access to dental services for children in Medicaid. However, information on the oral health of and receipt of dental services by Medicaid children show that more needs to be done. Although many states have reported moderate increases in access to Medicaid dental services, states responding to our survey reported that low provider and beneficiary participation, and administrative burdens—many of the same factors that contributed to the low use of dental services in 2000—still present barriers to access today. CMS's reviews of states' efforts have identified deficiencies in several state Medicaid programs, but CMS has not required corrective actions by states or planned additional dental reviews. In our report, we are making four recommendations to CMS to strengthen the agency's monitoring of state Medicaid dental services for children and help states improve children's access to Medicaid dental services. Our recommendations include developing a plan to review dental services for Medicaid children in all states with low utilization rates, ensuring that states found to have inadequate MCO dental provider networks take action to strengthen these networks, working with stakeholders to develop needed guidance on topics of concern to states, and identifying ways to improve sharing of promising practices among states.

In commenting on a draft of our report being released today, CMS generally concurred with all four recommendations and described several initiatives planned or under way that would strengthen its oversight of state Medicaid dental services for children. CMS indicated that the agency was developing additional guidance and technical assistance to states on the provision of EPSDT services, with a particular focus on access to dental services. CMS also reported that its efforts to implement the Children's Health Insurance Program Reauthorization Act of 2009 would include a number of activities related to dental services, such as a new quality measure program and new reporting requirements.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer any questions you or other members of the subcommittee may have.

For further information regarding this statement, please contact Katherine Iritani at (202) 512-7114 or at iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Kim Yamane, Assistant Director; Sarah Burton; Mollie Hertel; Sarah Marshall; Terry Saiki; and Teresa Tam also make key contributions to this statement.

Related GAO Products

Medicaid: State and Federal Actions Have Been Taken to Improve Children's Access to Dental Services, but Gaps Remain. GAO-09-723. Washington, D.C.: September 30, 2009.

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: Extent of Dental Disease in Children Has Not Decreased. GAO-08-1176T. 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.

Medicaid Managed Care: Access and Quality Requirements Specific to Low-Income and Other Special Needs Enrollees. GAO-05-44R. Washington, D.C.: December 8, 2004.

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

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

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

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

Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort. GAO/HEHS-97-86. Washington, D.C.: May 16, 1997.

Mr. KUCINICH. The Chair recognizes Ms. Mann. You may proceed.

STATEMENT OF CYNTHIA MANN

Ms. MANN. Good afternoon, Chairman Kucinich, Ranking Member Jordan, and members of the subcommittee. I, too, appreciate the opportunity to be with you today to talk about how children are faring receiving needed dental services under the Medicaid program; and I want to begin by commending you, Mr. Chairman, for your sustained interest in this area.

I have been the director for the Center for Medicaid and State Operations for a little less than 4 months, and I have not been a witness to the prior hearings. However, in my position at Georgetown University, I closely followed the proceedings. And now that I am director of CMSO and have taken stock of what we have done in the past period of time, it is clear to me that the activity that has happened was triggered in large part by the activity of this committee and by your interest in this area and that you have been able to plant the seeds for a renewed commitment on this very important matter.

While I am new to CMS, I am not new to this issue. As you noted in your introduction of me, I have worked on children's access issues for many years; and I would note that in my 18 months at CMS in 1999 and 2001 I helped author the letter that was issued in January 2007, which you referred to in your first hearing, which called for every State to conduct a dental access review.

Since that time, many States have made progress narrowing dental access gap for children. But, as the GAO correctly points out, significant gaps remain. We know from the research that there's an inextricable link between oral health and overall health and that every child needs dental care, preventive care, and treatment when appropriate.

Sadly, our country's record in assuring our kids have the dental care they need, both in private coverage as well as in public coverage, is not good; and the record is particularly poor for low-income children. I can assure you, Mr. Chairman and members of the committee, that Secretary Sebelius and I share a firm belief that we have a responsibility to do much more to assure that every child enrolled in Medicaid receives the dental care they need.

The data show that about 36 percent of all Medicaid-eligible children used dental services over a year's period of time. With that data, there can be little doubt that improvements are necessary.

States administer the program, they enroll the providers, they set the provider rates, but CMS plays a critical role, and we are intent on using all of the tools available to us to assure that every child covered by Medicaid is as healthy as he or she can be.

My written testimony lists a number of actions that CMS has taken over the past period of time since the last hearing. I am just going to review a few of those activities.

In policymaking activity, we are now actively involved in providing guidance in the area of children's health insurance coverage and the new CHIPRA provisions that expanded dental benefits for children in a number of different ways. In fact, today we released our guidance to States on the new CHIP dental health benefit and

the supplemental insurance option that's now available to States to provide dental coverage to children who have other sources of care.

CHIPRA also included several other provisions that we are working on. One was a provision that required the Secretary to publish the names of the dentists serving children in the Medicaid program in every State around the country, Medicaid and the CHIP program. We launched that Web site on August 4th and have those dental providers listed at this point. That Web site, I will say, is a work in progress.

We think that there's a number of improvements that we want to continue to make. We have had a number of—a lot of activity on that Web site, about 43,000 hits to the page, but there are improvements that can be done; and we think we can use that Web site not only to ultimately share information with families like Deamonte Driver's family about where to get dental care but also for us to use as a monitoring tool to be able to see what the numbers of dentists are in each Medicaid program, how many are taking new patients, and what that access looks like over time.

We also are intent on changing our data reporting system. We want to change the so-called CMS–416, which is our EPSDT reporting form, to include information about other providers that are providing oral health care, as well as to improve, to make other improvements to the 416; and we are planning to do that by the spring of this year. There were a number of requirements to changes in the 416 that were part of CHIPRA, so we want to consolidate those changes and put those out in the spring.

We are also partnering right now with the Agency for Health Quality and Research to come up with dental health quality standards as part of the overall initiative to come up with children's health standards. We believe that those health standards, those dental quality standards themselves, which will be reported by States, hopefully—it's a voluntary reporting by States—will again give us another window to assure that children are getting the care that they need and get States to pay continued attention to the need for oral health services.

We are also helped, as you noted, in your introductory remarks, Chairman Kucinich, by a new oral health and technical advisory group that's going to help us move forward in our policymaking. But a second area of——

Mr. KUCINICH. The gentlewoman's time has expired, but I will let you make a concluding statement.

Ms. MANN. Let me conclude by saying our two other areas that we are focusing on, besides policymaking, is identifying best practices, sharing those widely with States, meeting with States on best practices and then the issue of oversight.

On those 16 State reviews, on August 27th, I issued a letter to all of those States, saying that we wanted to know the results of those recommendations and those reviews. Our regional offices are now working with each of those States, and we will look at those reviews and also assess whether additional reviews are needed.

Thank you. I wanted to just close by saying that we are committed to continuing to make this a focus of our work as we go forward and always welcome your insights and your suggestions in terms of moving forward.

Mr. KUCINICH. I thank the gentlewoman.
[The prepared statement of Ms. Mann follows:]

STATEMENT OF

CYNTHIA R. MANN, J.D.

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

ON

ACCESS TO DENTAL SERVICES FOR MEDICAID RECIPIENTS

BEFORE THE

HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON DOMESTIC POLICY

October 7, 2009

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of

Cynthia R. Mann, J.D.
Director, Center for Medicaid & State Operations
Centers for Medicare & Medicaid Services

Before the
House Committee on Oversight & Government Reform
Subcommittee on Domestic Policy
On

Access to Dental Services for Medicaid Recipients

October 7, 2009

Good afternoon Chairman Kucinich, Ranking Member Jordan and members of the Subcommittee. Thank you for the opportunity to speak with you today about the initiative the Centers for Medicare & Medicaid Services (CMS) has taken with regard to access to dental care for children served by the Medicaid program. Mr. Chairman, we appreciate your ongoing concern and hard work to improve dental access for children receiving Medicaid benefits. CMS is committed to ensuring access to quality health care for all Medicaid beneficiaries, and access to dental services is a key part of this agenda.

Background

As you know, Medicaid is a shared partnership between the Federal Government and the States with estimated total State and Federal expenditures of $419 billion[1] in Calendar Year 2010. The Federal Government provides financial matching payments to the States, conditioned on each State designing and running its own program consistent with the Federal statute. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to meet the needs of their beneficiaries within their unique political, budgetary, and economic environments. As a result, there is considerable variation among the States in eligibility, services, and reimbursement rates to providers and health plans. States enroll providers, set reimbursement rates, and negotiate managed care contracts.

[1] 2009 National Health Expenditures Data (Table 3)

CMS has a key role to play in this unique Federal-State partnership. One of CMS's primary goals is to assure the program integrity of the Medicaid program. Program integrity is often used to refer to fiscal management of the program and fiscal management is certainly a central component of our mission. But program integrity also means ensuring that eligible individuals have ongoing and consistent access to the care that the Medicaid program guarantees them. Due in no small part to your efforts to improve access to dental services for children enrolled in Medicaid, Mr. Chairman, CMS has taken a number of important steps to improve oral health care for children. CMS is committed to continuing these efforts, and we are also taking additional steps to improve access to dental services for children in Medicaid. There can be little question that there is a significant and troubling gap between what Federal Medicaid law promises children in terms of oral health care, and what children actually receive. Working closely with States over the next few years, we intend to narrow that gap.

In my role as Director of the Center for Medicaid and State Operations (CMSO), I have made improving access to mandatory critical dental benefits one of my top priorities, not only because of the tragic events in years past, but because it is the right thing to do and furthermore, it is what the Medicaid program requires. The research has clearly established the inextricable link between oral health and overall health and we are taking several steps to acknowledge and formalize that link through policymaking, collaborative activities and oversight.

CMS Response to Improving Oral Health

As noted earlier, States, the District of Columbia, and the Territories administer 56 unique Medicaid programs with policy guidance and oversight from CMS. CMS is committed to working with the States to improve oral health care and access to that care through interventions focused in three strategic areas: improving access to dental services, with an emphasis on prevention; ensuring that reimbursement aligns with desired outcomes; and focusing attention on the quality of the dental services provided. We are approaching these interventions through different avenues including policymaking and data collection, collaboration with States and other partners to share experiences and best practices, and oversight. Because each State and each State's Medicaid program is unique and targeted to the population served, and because the problems we face are not the same in Atlanta as they are in Columbus, Orange County or upstate

New York, there is no one single activity that can be implemented to assure improvement. Improvement requires a persistent, robust and dynamic process that involves the Federal government, the States, the oral health provider community as well as other health providers, parents, and other key stakeholders.

1. Policy and Data Improvements

CHIPRA Dental Benefits

CMS is currently in the process of implementing the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).[2] CHIPRA was signed by President Obama on February 4, 2009 and ensures that States can strengthen their existing Medicaid and the Children's Health Insurance Program (CHIP) programs and provide coverage to additional low-income, uninsured children and pregnant women. CHIPRA also included a number of key provisions that firmly plant oral health within the scope of key benefits for both CHIP and Medicaid.

Medically necessary dental services for children have always been covered for Medicaid-enrolled children through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements and CHIP children who are enrolled in Medicaid-expansion CHIP programs. The enactment of CHIPRA provides the opportunity to reach more children and provide them with necessary dental services by requiring that States operating separate CHIP programs provide coverage of dental services.[3] Dental care was previously an optional benefit for separate CHIP programs, although all States had elected to cover some level of dental benefits.

The CHIPRA dental requirements became effective October 1, 2009, and require all States to provide comprehensive dental benefits to children enrolled in CHIP. Each State's dental benefit must cover "dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions." States may achieve this standard using one of two options: 1) Adopting one of the dental benchmark benefit packages

[2] Public Law 111-3
[3] Public Law 111-3. Section 501.

specified in CHIPRA such as a State employee benefits package or 2) Developing a State-defined CHIP dental benefit that meets the new Federal standards.

In addition, for the first time, States with separate CHIP programs have the option to supplement children's private health insurance with a dental coverage plan financed through CHIP. This is a new provision in CHIPRA that recognizes that while many children in the CHIP income range may have insurance for medical care, they lack dental coverage. Prior to CHIPRA, States were not permitted to provide this supplemental coverage because children had to be uninsured to enroll in CHIP. We anticipate that this new supplemental coverage will help assure that many more children have access to comprehensive benefits that include coverage for oral health services.

CMS Oral Health Technical Advisory Group

To assure consistent State input in our policymaking related to oral health care, CMS developed an Oral Health Technical Advisory Group (OTAG). The first meeting was held in July 2008 and the OTAG continues to meet on a regular basis, generally every four to six weeks. The OTAG includes a State Medicaid Director who serves as the Chair, seven State Medicaid and/or Dental representatives, and two State CHIP Directors. The OTAG works closely with CMS staff on technical policy issues related to the operation of the Medicaid program. The OTAG has advised CMS on many dental-related issues, including the development of a "Questions and Answer" policy document that addresses the most recurring Medicaid dental issues. This document is available on the Medicaid Dental Coverage Web site available at http://www.cms.hhs.gov/MedicaidDentalCoverage/.

National EPSDT Workgroup

Our policymaking, guidance and training agenda will be further guided by two new initiatives that are being launched to augment CMSO's focus on oral health: an EPSDT listening session and a National EPSDT Workgroup.

As a first step to developing the EPSDT workgroup, CMS has scheduled a "listening session" to take place on October 16, 2009 to hear input from stakeholders on their experiences and

recommendations for improving the implementation of EPSDT services, including dental services. We have invited a broad audience of interested individuals and organizations to participate in this listening session to provide CMS with initial input to help us focus on areas that would be of most use to States, providers and other organizations. We are considering replicating this listening session on the regional level.

CMS will use the feedback gathered from the listening session to convene a national EPSDT workgroup, with participation from other Federal agencies, States, oral and medical health providers, consumer groups, advocacy organizations and researchers. The direction of this effort will be informed by the listening session, but in general we believe that individuals participating in this group will be able to assist CMS by helping us to prioritize and design projects such as improved data collection and appropriate periodicity schedules. Some of the tasks that may emerge from the workgroup will include updating the State Medicaid manual and issuing updated policy guidance through regulation, and the provision of training and support to State Medicaid and CHIP programs.

Improved Data Collection

CMS is committed to capturing more accurate dental information from States in order to analyze and monitor progress in the provision of dental services. We are working to ensure the accurate submission of dental services data on the CMS-416 form which provides basic information on participation in the Medicaid program. Specifically, the form provides CMS with information on the number of children provided child health screening services, the number of children referred for corrective treatment, the number of children receiving dental services, and the State's results in attaining goals set for the State under section 1905(r) of the Social Security Act. The information is used to assess the effectiveness of State EPSDT programs.
CMS is working to improve data collection on the CMS-416 by adding two new lines of data to capture improved information on all types of State providers delivering dental or oral health services to children. CMS is aware that many States are utilizing new provider types or expanding the scope of practice for existing dental providers. In order to address these changes in service providers, CMS sought input from the OTAG to determine how we could capture those services provided to Medicaid eligible children from the non-dentist providers. With

OTAG input and concurrence, we designed modifications to the CMS-416 to include reporting on the number of children who receive an oral health service from a non-dentist as well as the total number of children receiving any dental or oral health service.

After development of the new form, CHIPRA added new requirements to the data collected on the CMS-416 Form. Specifically, beginning April 1, 2011, CHIPRA requires CMS to report data on the number of children in the age grouping that includes age 8 (6-9 year olds) who have received a protective sealant on at least one permanent molar tooth. The first permanent molars generally erupt between ages 6 and 9, and it is recommended the molars be sealed reasonably soon after eruption to protect the pit and fissure surfaces of the teeth. Sealants reduce the risk of pit and fissure caries in susceptible teeth and are cost-effective when maintained. In addition, we will be collecting data to separately determine the number of children that are receiving dental services under a CHIP-funded Medicaid expansion plan. Because CHIPRA required changes to the CMS-416, CMS felt it would be confusing and burdensome to require States to change to a new version of the form in two consecutive years. In addition, we are now considering a broader set of revisions to the form to improve data collection regarding EPSDT services for children. Therefore, CMS did not issue a new form in 2009; States will use the current form to report their 2010 data and CMS will consider the inclusion of the previously approved dental data when we make the CHIPRA-mandated changes to the form. We intend to have the revised CMS-416 to States in Spring/Summer 2010.

2. Outreach, Collaboration and Sharing of Best Practices

Dental access problems are not simple to solve but many States are making headway by experimenting with different types of approaches. As described briefly below, CMS has several initiatives underway to identify, evaluate and share information about promising practices such as streamlined administrative processes, use of mobile dental services, and collaborations with Head Start or other public health programs. A "promising practice" represents a State approach to meeting a challenge related to Medicaid or CHIP program operations, clinical practice, or functional level that serves to enhance quality of care and/or life and may be of interest to other

States. The CMS Promising Practices[4] Web page contains a list of promising practices that have been vetted for publication as well as information on the process for submitting a promising practice for consideration.

National Medicaid Dental Town Hall Forum

On April 6, 2009, CMS held a National Medicaid Dental Town Hall Forum in Baltimore, Maryland. The overall intent of the Forum was to bring together interested parties to present their views, concerns and recommendations related to oral health issues. In addition, it provided a venue for participants to furnish feedback on various oral health issues and to discuss best practices and innovative delivery modes for dental care. The Forum was held in conjunction with the National Association of State Medicaid Directors (NASMD), representing our State Medicaid partners, and the American Dental Association (ADA), representing our provider partners. CMS asked three State Medicaid dental programs that have made significant progress in their programs through various innovations or partnerships to make presentations. In particular, Virginia highlighted the successful partnership it developed between its State Medicaid program and the State's Dental Association. Other partnerships that were presented included those between State Medicaid programs and dentists, and successful support provided by the Maryland State legislature. Arizona demonstrated that a managed care model can be a successful option for some States.

CMS received significant comments and input from the forum participants. Over 115 individuals registered to attend the Forum in person, and 250 individuals participated via a webcast of the Forum. Many participant comments focused on the three areas that CMS had highlighted for discussion: payment opportunities (including increased reimbursement), delivery of dental services through managed care organizations, and education and communication of information to dental providers and Medicaid beneficiaries. Additional subjects that were raised as public comments included how the absence of adult dental coverage in a State's Medicaid program negatively impacts the provision of dental services to children; dental workforce challenges, in particular, the need for pediatric dentists and dentists with specialized training in treating those with special needs; and the need for stronger links to family practitioners and

[4] http://www.cms.hhs.gov/PromisingPractices/

pediatricians. CMS received very positive feedback about the Forum and intends to use the information received in our future work on dental and EPSDT services.

Quality Measures

CMS is also currently engaged with the Agency for Healthcare Research and Quality (AHRQ) in developing recommendations to the Secretary for quality measures for children. CHIPRA requires that the Secretary develop a set of core quality measures for Medicaid and CHIP by January 2010, and by 2011 for all pediatric care. Reporting under these measures is voluntary for the States. The objective is to develop and adopt measures that can guide programmatic decisions and contribute to our knowledge of what is and what is not working for our nation's children. The initial core set of child health quality measures must include "dental care, conditions requiring the restoration of teeth, relief of pain and maintenance of dental health." AHRQ convened a meeting of the National Advisory Council Subcommittee on Quality Measures, of which CMS is an *ex-officio* member, which recommended three dental quality measures for consideration to be included in a comprehensive, initial core set of quality measures for voluntary State reporting starting in 2011. Once these measures are adopted, we will work closely with States to promote reporting on these measures and to create opportunities for States to identify and share best practices that enhance children's access to quality dental care.

Additionally, both CHIPRA and the American Recovery and Reinvestment Act of 2009 (the Recovery Act) provide State Medicaid programs multiple opportunities to adopt, implement or upgrade health information technology (HIT) to implement electronic health records. This transition to more advanced technology offers new and potentially groundbreaking opportunities to improve quality as well as data collection in health care service delivery.

Insure Kids Now!

On August 4, 2009, CMS and the Health Resources and Services Administration (HRSA) launched a dental page on the Insure Kids Now![5] Web site to make information on dental providers and benefits readily available as required by CHIPRA. The site provides a current list of all Medicaid and CHIP dentists and providers within each State and a description of the

[5] http://www.insurekidsnow.gov/

Medicaid and CHIP dental services that are covered in each State. These new requirements were intended to make it easier for families to identify dental providers in their area that accept Medicaid and CHIP patients. To date, there have been over 43,000 hits on the Insure Kids Now! Web site. Further improvements to the site are planned, but in the short time since the new portion of the Web site launched, CMS has received several notes of positive feedback and also requests from dental providers across the country asking for information on how they can become a Medicaid or CHIP provider.

Working with Providers

Building upon CMS' previous work with the dental professional community, the American Dental Association has agreed to take the lead for the Dental Quality Alliance (DQA). One goal of the DQA 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. DQA has set December 4, 2009 for the first meeting of the Steering Committee for this Alliance. The Steering Committee will establish rules, parameters for membership, and the agenda for the DQA. It is expected that the DQA will include members from all oral health organizations involved in dental care delivery. CMS has been offered a seat on the DQA Steering Committee and will continue to provide leadership in this endeavor. 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.

Oral Health Education for Parents of Newborns

On the prevention side, CMS is beginning its work with various partners both in and outside government to meet the CHIPRA requirement for dental education for parents of newborns. Specifically, CHIPRA required that the Secretary develop and implement a program to deliver oral health educational materials to inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within their newborn's first year. This initiative provides us with a terrific opportunity to form new partnerships with the goal of educating parents of the need to perform oral hygiene on babies as soon as the first tooth erupts.

Opportunities for Improved Access

As States work through access to dental care challenges, some are developing local solutions, in keeping with State licensing requirements and scope of practice limits, to engage dental hygienists, pediatricians and others to assure that families learn about the importance of oral health and have access to needed care, regardless of whether they live in an urban or rural community or on an Indian reservation.

Our colleagues at HRSA also provide critical support for oral health through workforce development activities as well as facilitating direct patient care. HRSA operates several oral health workforce programs that support students, residents and practitioners. For example, in 2008, HRSA awarded $10 million to support 259 general and pediatric dentistry residents. There are also 424 dentists and dental hygienists participating in the National Health Service Corps providing over 1 million patient visits per year and placing oral health providers in underserved communities. In addition, HRSA supports direct patient care through Federally Qualified Health Centers (FQHCs) and other community health centers which are largely financed with Medicaid funds. In 2008, health centers employed 2,299 dentists, 892 dental hygienists, and 4,329 other dental staff.

3. Oversight

We expect that improved guidance and data, training, and providing new opportunities to share best practices will help move the Medicaid and CHIP programs forward in terms of assuring appropriate access to dental services for children. At the same time, oversight and review of State practices and access problems remains a top priority for CMS.

Focused Dental Reviews

Mr. Chairman, as you know, in 2008, CMS completed 16 State dental reviews[6] targeting States with low dental utilization for children receiving Medicaid. The purpose of the reviews was to determine what efforts each State had planned or implemented to address the issue of dental

[6] States reviewed: Arkansas, California, Delaware, Florida, Georgia, Louisiana, Michigan, Missouri, Montana, Nevada, New Jersey, New York, North Dakota, Pennsylvania, Wisconsin and the District of Columbia.

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, and conducted extensive document reviews in the areas of outreach, periodicity, access, diagnosis and treatment services, support services, and coordination of care. Additionally, CMS reviewed information collected from families of children enrolled in Medicaid. Based on these interviews and the State dental reviews, in January 2009 CMS released the 2008 National Dental Summary of the findings from these individual State reviews.

Some of the more concerning findings include: States not meeting the requirement for timely dental access standards or lack of monitoring provider networks for adequacy; States not following the required dental periodicity schedule requirements; and one State was identified as limiting access to medically necessary EPSDT services. The 2008 National Dental Summary report includes several recommendations for State action. Specifically the report recommends that States should: track which children have not received services and take steps to ensure access to dental care; consider innovative approaches to delivering dental services; and consider working with leaders in the dental community and in the provider community more broadly to develop incentives and encouragement for expanding provider enrollment in Medicaid.

As a follow-up to these reviews, CMS is re-engaging each of the 16 States to determine the current status on dental utilization improvement efforts. While these subsequent dental reviews are ongoing, a few promising practices have already emerged. Selected counties in one State have increased access to dental services through use of County Health Department run mobile dental vans in schools. A multi-site FQHC in one State reported success by cultivating an atmosphere of mutual respect to encourage compliance with dental appointments, which ultimately increased access. One State reported a 90 percent compliance rate for their Head Start population. Several States reduced administrative burdens for providers by reducing prior authorization requirements and developing more user-friendly administrative processes. We plan to continue to work with States to review the actions they are taking to improve access to oral health care for their Medicaid-eligible children and to identify where further improvements are warranted.

Periodicity Schedule Review

In addition to the 16 State-focused dental reviews in 2008, CMS collected information on the availability of dental periodicity schedules from all 50 States and the District of Columbia. All but three States reported having some type of periodicity schedule, although it appeared that not all were in compliance with Federal 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.

In response, the CMS Regional Offices contacted every State and outlined the expectations for an oral health periodicity 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 children's dental health care. All states now have dental periodicity schedules. CMS will continue working with States to assure that their periodicity schedules meet CMS requirements.

Issues Noted by the Government Accountability Office (GAO)

The GAO has stated that CMS should develop a plan to review dental services for Medicaid children in all States with low utilization rates. CMS concurs and recognizes the need to continue the State review process and to increase our focus on improving access to dental services for children enrolled in Medicaid to ensure that children receive the full scope of services available under the EPSDT benefit. To this end, CMS has undertaken a number of activities related to improving access to dental services for all eligible children as described above.

In an effort to identify areas where States have been successful in providing comprehensive oral health care to Medicaid beneficiaries, CMS is scheduling site visits with States that have high dental utilization data, based on reports from the 2008 CMS-416 data. This aligns with GAO's comments that CMS perform additional dental reviews to further examine oral health access across the States. In addition to the targeted dental reviews, CMS is discussing many ways to

include dental services within the context of larger EPSDT program reviews. We have also just received a request from one State to perform an on-site dental review of their Medicaid program.

The GAO has also mentioned that CMS should ensure that States found to have inadequate dental provider networks within their managed care organizations (MCOs) take action to strengthen those networks. CMS agrees that States must ensure that MCOs offer an adequate network of providers for Medicaid beneficiaries to choose from, both dental and otherwise. There are requirements for States to ensure, through their contracts with managed care entities, that each entity "Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract."[7] We believe this language includes oral health providers. Regulations further require States to obtain supporting documentation of the adequacy of a managed care entity's provider networks. CMS cannot approve contracts without these requirements being met. However, once a network is verified for purposes of contract approval, changes in networks can occur. In some instances, previously open panels of physicians or dentists may become filled to capacity, providers may drop out of a network, or other challenges may occur which can create an issue with ongoing provider availability. As one means of addressing this issue, CMS is working with States to implement the CHIPRA requirement that all States post a listing of participating Medicaid and CHIP dental providers on the Insure Kids Now! Web site as noted above.

The GAO has also indicated that CMS should work with stakeholders to develop guidance on topics of concern to States and identify ways to improve the exchange of promising practices among States. CMS understands the value added by stakeholders and we are actively engaged with a range of partners that share our goal of making the Medicaid program the most effective program it can be. These outreach efforts are evidenced by the OTAG, CMS's recent Town Hall meeting, listening sessions and ongoing workgroups that are in early phases. As stated earlier, CMS is committed to working with our partners to continue improving access to dental services for children. CMS is also dedicated to the effort of sharing promising practices among States and other stakeholders.

[7] 42 CFR 438.206(b)(1)

Conclusion

In conclusion, States and CMS continue to make strides in improving access to oral health care for children enrolled in Medicaid and CHIP, but much more must be done. The downturn in the economy threatens some of the gains that have been made and has the potential to stall future progress in the absence of continued, focused, and proactive efforts to improve access to dental services for all Medicaid and CHIP-eligible children. The opportunities provided by CHIPRA and the Recovery Act, and the interest among many States, provider organizations, children's advocates, philanthropies as well as the attention that you give this issue, Mr. Chairman, give us reason to be hopeful and excited about the potential opportunities for improving oral health care for children. Thank you again for the opportunity to speak with you today.

Mr. KUCINICH. We are going to go to questions of the witnesses. The Chair and the ranking member will have 10 minutes for questions and followed by 5 minutes from other Members' questions. We will see how we go in the rounds, whether we go one rounds or two rounds.

I will begin by asking Ms. Iritani, does GAO have an estimate of the number of Medicaid-eligible children who did not receive a single dental service?

Ms. IRITANI. Yes, we do.

Mr. KUCINICH. How many?

Ms. IRITANI. That would be 12.6 million on the basis of nationally representative surveys.

Mr. KUCINICH. Thank you.

What percent of children does that work out to be?

Ms. IRITANI. That's 66 percent of Medicaid children.

Mr. KUCINICH. So the reality is that—you say 66 percent of the eligible children do not receive dental services. Meanwhile, the Department of Health and Human Services has established a national goal of achieving 66 percent of eligible children who do receive dental services by next year. So we've got 66 percent not receiving, and the goal is 66 percent who will receive the preventative dental services. That is, to achieve the national goal, we're essentially going to have to turn the current statistics on their head.

Now, Ms. Mann, you've inherited an agency that, for the better part of a decade, has been held back from making progress toward this goal.

For instance, when we asked the official who preceded you what it was going to take to increase access to dental services, he indicated there wasn't much he could do. He didn't believe that he could require corrective actions of the States. What do you believe?

Ms. MANN. I think there's a great deal that we can do, Chairman. I believe it's a multi-pronged problem, and we have an obligation to have a multi-pronged solution. I think it's both——

Mr. KUCINICH. Excuse me. Those are words.

Ms. MANN. I think we have to give some guidance to States. If they're looking for guidance on how to set dental rates, we will provide that guidance on how to set dental rates. I believe we need to do oversight. As I mentioned, we are following up with each of the 16 States that we did the initial reviews. There had not been followup till I got back—until I came on at CMSO, and we will assess whether additional State reviews are necessary. What I want to do is focus on these 16 States, see where we are, see what progress has been made.

I do think that CMS can do corrective action plans. We plan on doing it in a number of different areas where it's necessary. I'd like to work with States and share best practices. These are complicated areas. These are troubling.

Mr. KUCINICH. OK. We're going to get into the corrective action in a little bit. I want to go back to Ms. Iritani—excuse me—and thank you. We're, you know, trying to create a dialog here.

Ms. Iritani, in your testimony, you mentioned that more than half of the 21 States that provide dental services through managed care organizations have reported that MCOs in their State do not

meet any—or only meet some of the State's dental access standards.

Approximately how many children are going without dental services in those States?

Ms. IRITANI. That's a difficult question to answer, because, unfortunately, the data by delivery system is not reliable. So the 416 that captures the data on access by delivery system, we have found, does not break out managed care versus fee for service for access, and those States do not have managed care throughout the State.

Mr. KUCINICH. OK. If we're looking at achieving a goal then, we need to really have some quantitative assessment of where we start. Do you have any guess at all? Do you have a best guess of what that number would be as to how many children are going without dental services in the States?

Ms. IRITANI. In the States that have managed care?

There are 21 States that reported that they have managed care——

Mr. KUCINICH. We know that.

Ms. IRITANI [continuing]. But in some of those States, the managed care penetration rate—that is the number of children that were receiving dental services through managed care—was very low.

Mr. KUCINICH. OK.

Ms. IRITANI. So we can't answer that question, unfortunately.

Mr. KUCINICH. We're going to work with you to help get the breakdown so we know where the targets are in terms of the goals that we have to reach. We have to know where we're starting and since it is on a State-by-State basis, so we're going to need your help on that.

Now, Ms. Mann, this subcommittee found that UnitedHealthcare, as an inadequate dental provider network, was a contributing factor to the preventable death of Deamonte Driver. As you know, CMS recently conducted a significant review of dental services in 17 States, and you identified eight States where Medicare managed care organization provider networks were not assured of being adequate to provide access to dental services.

Ms. Mann, do you believe that inadequate dental provider networks in Medicaid managed care organizations are a significant barrier for children to receive dental care?

Ms. MANN. Chairman, I think there's an access problem inside managed care and outside managed care, and actually——

Mr. KUCINICH. Well, let's talk about inside managed care. What do you believe?

Ms. MANN. I think it depends on each State, and in some States, their managed care organizations are not providing a sufficient network.

Mr. KUCINICH. OK. So what are you saying? It depends on each State. That's not—I need something more specific here. You're giving me answers that are interesting, but they're very general, and the way that this committee works is we learn by getting specific answers.

Can you be specific?

Ms. MANN. Each State is different, Chairman, so I can't tell you that there is—it's not that inherently managed care is a problem. It is that every State has an obligation to make sure that network is sufficient. In those eight States, we're following up specifically to look at what steps those States have taken to ensure——

Mr. KUCINICH. OK. Now, each State is different. Thank you. Now I'm focusing on Medicaid managed care organizations because they behave like a traditional HMO in the Medicaid context, retaining the risk in exchange for capitation fees. Under Medicaid, they make money when their enrollees don't get medical and dental care.

This subcommittee held a hearing last month on the health insurance industry and the industry spending—on numbers, health care is known as medical losses, and insurance company executives try hard to keep those losses to a minimum. Obviously, one of the ways a for-profit Medicaid managed care organization can please Wall Street and can keep their medical losses to a minimum is by making it difficult for people who are covered to find a dentist who will accept Medicaid.

In your opinion, have you seen any evidence that dental utilization rates differ according to whether a State relies upon for-profit Medicaid managed care organizations to provide coverage?

Ms. MANN. The study that I have seen is the study that actually you asked for, Chairman, in the CRS report, and it certainly showed dental access problems. I have not seen a more broad across-the-board study of it. I think that the evidence is that, in risk-based contracts, there can be a greater propensity for denial of care, and therefore there is a greater obligation, if the State chooses to set up its system that way, to oversee and make sure that care is sufficient. Medicaid obligations——

Mr. KUCINICH. OK. Now we're making some progress here. I would like to ask that you and your staff consider correspondence received by my staff from Dr. Burton Edelstein in which he finds evidence for a correlation between Medicare managed care organizations and lower dental utilization rates. Did you collect data from the States which would allow you to determine if this is a factor, if there is a correlation between Medicaid——

Ms. MANN. You asked about for-profit managed care organizations. I have not looked at data looking at for-profit managed care organizations. We can look at that more closely, Chairman, and I'd be glad to look at that more closely.

Mr. KUCINICH. Good. Thank you.

Ms. MANN. I will say that we have a real problem in the fee-for-service area as well, and so I think that——

Mr. KUCINICH. Well, that's not what this hearing is about, though, is it?

Ms. MANN. I thought the hearing is about Medicaid access for children.

Mr. KUCINICH. OK. Ms. Mann, do you believe that inadequate dental provider networks, where they're connected to this for-profit motive, are one of the reasons why so many of these children are not getting health care? Is it because of the way the system is structured?

Ms. MANN. I think that Medicaid managed care organizations can make it worse or can make it better depending upon what the financing looks like, what the incentives are and what the oversight is.

Mr. KUCINICH. I want to ask you about one of GAO's findings that troubles me.

In testimony before this subcommittee in September 2008, interim director Herb Kuhn testified: CMS will require corrective actions for those States not in compliance with Federal regulations.

However, you told GAO that you will only followup with States but had no plans to require action from them. As you wrote in a cover letter, "These were programmatic reviews, and as such, formal, corrective action plans," were not required.

I'm wondering if CMS has backed down from its earlier commitment to this subcommittee to require corrective actions from the States?

Ms. MANN. As I stated a moment ago, we believe the corrective action plans are part of our toolkit in terms of moving forward on the Medicaid program. These reviews were done, as you noted, before I came, and they were set up as technical assistance reviews.

Mr. KUCINICH. So you plan to require corrective action plans?

Ms. MANN. Can—if I could finish?

Mr. KUCINICH. Well, just can you answer that question, though?

Ms. MANN. If there—when we complete these reviews back from the regional offices, if we still see problems, then we will move forward in a separate action for corrective action plans, yes.

Mr. KUCINICH. So you're not adverse to corrective action plans?

Ms. MANN. Absolutely not.

Mr. KUCINICH. And you'll be letting this committee know about timeframes for the component of that requirement?

Ms. MANN. Sure.

Mr. KUCINICH. OK. Thank you very much.

The Chair recognizes Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

Let me pick up where the chairman was.

The first question or the first point he made was only a third of children—this, I guess—I think—I assume he got his information from the same place I did—from a GAO study last year. Only one in three children are getting treatment for tooth decay and other dental problems. So I just want to, I guess, cut to the chase.

Have you seen an improvement in the past year? Is it better now? What is the status? And I understand that this is last year's study, but here we are late in 2009. What kind of improvement have we seen in helping these kids?

I'll go to Ms. Mann first.

Ms. MANN. The data from the last 2 years shows a slight improvement from 33 percent to 36 percent of kids having a dental visit in the past year. So we're—nationwide, we're moving, albeit very slowly, in the right direction.

Mr. JORDAN. I would say most people would say that's really slowly in the right direction. OK.

Ms. Iritani, do you want to comment?

Ms. IRITANI. Yes, and we've seen the same data.

Mr. JORDAN. OK. Let me just bring up something to Ms. Iritani.

You talked about one of the things that States have reported is this rather heavy administrative burden. In fact, I remember my days working at the Statehouse, and you talk to local officials. It's always, you know, dealing with the Federal Government—dealing with county government, dealing with the State government and the Federal Government.

So, A, is it true? Do you feel like there's a big burden you've placed—that has been placed by the Federal Government on States, and you know, what ways can States better navigate this and better deal with this situation?

We'll let both of you go at it.

Ms. IRITANI. We asked States about the barriers in their States to providers serving more children. Most States actually reported broken appointments—patients missing appointments as a major barrier. Administrative requirements was reported as a major barrier to providers serving more children by about 28 States, so not as much of an issue.

Mr. JORDAN. Would you be supportive of—and it's one of the things I worked on in my days at the Statehouse because of the whole welfare reform thing. Would you be supportive of some kind of penalty for—I'm just curious—for parents who—the appointment has been made. You know, it's in place. Would you be in favor of some kind of penalty for families who don't bring their child for that appointment?

Ms. IRITANI. We asked States about model practices, and I think there are States that are actually dealing with the broken appointment issue without a penalty situation. Virginia, for example, reported on a broken appointment initiative whereby they tracked broken appointments and tried to help patients get to their appointments.

Mr. JORDAN. OK. Go ahead. I interrupted you. Go ahead. What other actions are being taken to help States deal with the administrative burden?

Ms. IRITANI. Our report didn't look at those issues.

Mr. JORDAN. Ms. Mann.

Ms. MANN. Representative, just to be clear, the Federal Government does not in this instance require any paperwork that the States use to enroll their providers. So there—I have been—as GAO has reported, 28 States identify and providers often have identified that paperwork is a problem. If so, it's a State-initiated problem, and it's one of the things that, I think, is routinely on States' lists to try and address, and I think some of the States here to testify today will talk about what they've done to——

Mr. JORDAN. It's an internal issue?

Ms. MANN. It's a State—it's a State issue.

Mr. JORDAN. OK. OK.

Ms. MANN. It's—to the extent that it's causing barriers, we regard it as a CMS issue—an oversight issue, but it's not requirements that we put on States.

Mr. JORDAN. OK. OK.

Let me ask you—one of the things I remember—and this is, oh, probably 15, 20 years ago—I guess 15, 18 years ago—and maybe it would be better for the second panel, but in Ohio—this was way back when I was just—when I was assistant wrestling coach at

Ohio State University. One of the programs they had in place was the dental school would—we knew about it because I was, you know, employed at Ohio State, but you know, we had four children, so we were looking to get the cheapest care possible for our kids.

We took them to the dental college—the dental school, and we were very pleased, and it was very—you know, very inexpensive. I don't know what it cost, but I just know, when you're, you know, a young couple and you've got four kids—or maybe at the time we only had three—you're looking to save dollars wherever you can. It seemed to work. It seems to me that's a concept where, you know, here is a State institution receiving all kinds of taxpayer support already, many times in large metropolitan areas. That's something that we should be encouraging, and again, I was looking ahead in my briefing book here. I think we're going to hear from one of our witnesses about this issue, but—about this type of program. That makes all the sense in the world to me. It may be a little more difficult in rural areas where there may not be a dental school as close, but you've got to believe that's a way to help meet this need and not cost the taxpayers more money, which is obviously something that I know I'm concerned about, and I assume—and I think the rest of the committee is as well.

So, if you could, talk about that concept and what's going on already and how we can encourage more——

Ms. MANN. I think there are a number of dental schools that are providing direct services. Also, there are some new programs being involved, and we are trying to think of partnering with them in order to provide some payment for training, so—and also some loan repayment programs so that the dental students that get trained go out into low-income communities. There's also county health departments that are providing dental health services and a lot of federally qualified health centers.

So, I think, looking at all of those avenues to build our work force in terms of oral health providers is right.

I was just talking to a State legislator yesterday from Kansas. They don't have a dental school in Kansas, so that's why each—you know, each State you need to think about the different—the landscape and what can work, but I think the dental schools have been—can be very critical.

Mr. JORDAN. Do either of you know how many States are implementing such an approach right now with one of their dental schools or, maybe, with their single dental school?

Ms. MANN. I don't know, but we can find that out and get that information to you.

Mr. JORDAN. It seems to me if it's like—look, if that's working and, you know, many States have dental schools——

Ms. MANN. Sure.

Mr. JORDAN [continuing]. It's certainly something we should be doing; and again, not reinventing the wheel, we're always talking about the reimbursement rates and what providers—these are dental students. They need patients to learn their craft on, so it makes sense to me.

Ms. Iritani, did you want to comment? Do you have any idea——

Ms. IRITANI. I think that there are many States that have innovative practices such as that, and we recommended to CMS that they develop more ways for sure.

Mr. JORDAN. You don't know the number, though? OK. OK.

Mr. Chairman, I'll yield back the balance of my time.

Mr. KUCINICH. I thank the gentleman.

The Chair recognizes Mr. Cummings. He may proceed.

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

I want to thank you both for your testimony.

I must admit that, Ms. Mann, I'm feeling a feeling of deja vu in that, under the previous administration with CMS, so often this committee felt like we were getting the rope-a-dope, and I want to be specific because I'm talking about the lives of children. You said that there were things that you were willing to do.

Mr. Chairman, I hope you will understand what I'm about to say. I want to make sure that Ms. Mann is held accountable, and I want specific commitments for these children. We've been through a process, Mr. Chairman, as you will recall, where we were told things, and nothing happened. Now, either we're going to get some specifics as to what is going to happen and address these children's needs as the urgency of now, to borrow President Obama's words—because it is the urgency of now when only one-third of our children are getting what they need so that they can grow up and be able to sit at a table like that, to be able to go to school without pain, to be able to live a healthy life or we need to do something different. We need to be specific.

Ms. Iritani, you said here that CMS agreed to three of the four recommendations—is that right?—and partly the fourth; is that correct?

Ms. IRITANI. That's correct.

Mr. CUMMINGS. And which ones did they partly agree to?

Ms. IRITANI. They agreed, in part, with our recommendation to conduct reviews in all States with low dental access rates. They indicated that they would consider conducting additional reviews in the context of other programmatic reviews.

Mr. CUMMINGS. All right.

Ms. Mann, you said that there were things that you all were going to do. Can you go down each one of the things that you said you're going to do or are doing and give us timetables now? Because the way we like to operate is we like to bring you back on the date within a week or two after you say it's going to be done so that we can make sure it's done. See, we have a limited amount of time to be in these jobs. We may not win the next election, and so we have to be—we want to make sure that we are effective and efficient while we are here. Other than that, we might as well go and play golf. So the question becomes:

What are you willing to do? When are you going to do it?

Mr. Chairman, you set the schedule, but I would like for that—so that we can come back and check with Ms. Mann as to what—if she makes a commitment that we be able to have her come before us and let us know that the commitment has been completed.

Mr. KUCINICH. Will the gentleman yield?

Mr. CUMMINGS. Yes, of course.

Mr. KUCINICH. This is our fourth hearing, and you've been instrumental in creating every one of these hearings; and as I indicated in my opening remarks, we are going to stay on this. So we're going to get to know each other real well, and we're going to have a chance to be able to compare notes and establish metrics, timetables, completion of items because look where we are—66 percent are not getting the dental services to which they are entitled; and the goal is for 66 percent of children to get it.

So, with your persistence and in working with Mr. Jordan and our subcommittee, I think we've got a long way to go, but Ms. Mann is now on that road with us, so we'll look forward to working with you.

Now I yield back to Mr. Cummings.

Mr. CUMMINGS. I just want to go through the things that you—the action that you are going to take and when you expect to have it done. That's all. I mean, you can be brief. You talked about it a little bit already, but I just want to know exactly what you're going to do to correct this situation to get to that goal.

Do you agree with the goal, first of all?

Ms. MANN. Absolutely.

Mr. CUMMINGS. OK. Just tell us what you plan to do.

Ms. Mann, don't take this personally.

Ms. MANN. I'm not.

Mr. CUMMINGS. I'm serious. I'm speaking about the kids. You know, the chairman talked about himself. I was the same little kid who got all kinds of dental treatment later in my life. I've got kids right now in Baltimore who are going to the University of Maryland Dental School because of Deamonte Driver, in part, and they're discovering that the infection has gone to their eyes. See, apparently—I don't know that much about dentistry. Apparently, it goes to your eye before it goes to your brain, and I'm talking out for those little kids because I want them to grow up.

So that's why I'm kind of pushing hard on this because I don't want us to be making these same arguments a year from now or 2 years from now, and then some kid who only has, by the way, a limited amount of time to be a child—I don't want to be in the situation where that child is either harmed because we did not do what we could have done. I want every child—I think it was Masloff that says we must be what we can be, and I want every child to be what he or she can be.

So you can go ahead and tell us when you're going to do what you're going to do, what you're going to do, and then I'm sure the chairman will deal with scheduling hearings appropriately so that we can measure our progress.

Ms. MANN. There are a number of actions already underway.

As I noted on August 27th, I wrote to each of the States that had 16—the 16 States that had reviews. The regional offices are currently engaged with those States. I can commit to you that, in 30 days, we can tell you a response from those followup reviews from the regional offices and let you know where we stand on each of those reviews.

We have a listening session on EPSDT and where we should go on EPSDT, which is, as you know, the children's benefit package in Medicaid, scheduled for October 16th. That's the first. We plan

to have a few in that series to help guide us on one of the most important actions we can take going forward. I'm happy to commit to you the week after that October 16th listening session to let you know exactly what the recommendations were going forward.

We plan to do dental reviews in each of the States that are at the top of the list to identify, as the GAO has recommended, what those best practices are, and I can commit to you to provide you that information in the next—I have to figure out exactly when we can do those reviews, but I can followup and give you an exact date as to when we can do those and when we can provide that information.

Mr. CUMMINGS. Can you give me an outside date?

Ms. MANN. Sure. I would say by December.

Mr. CUMMINGS. OK.

Ms. MANN. We have committed to do the change in the 416 report by the spring of this year. We have a number of changes that we've already developed; and then there's new legislation in CHIPRA that we want to incorporate in those changes, and we want to do some consultation with experts. So we are having that consultation. That's part of the listening session that's scheduled for October 16th. We are doing that consultation this fall. We are going to be doing those changes this spring in the 416, which is to improve some of the data collection issues so that we can give you the numbers that you're looking for so that we can have a better idea and a more accurate idea, whether it's in managed care or fee for service, how many kids are or aren't getting the services that they need.

Mr. CUMMINGS. I see my time has expired.

Thank you, Mr. Chairman.

Mr. KUCINICH. I think, Ms. Mann, you can tell by Mr. Cummings' remarks that this committee needs your cooperation and that we are not going to stand by and watch any more little kids dying. Don't take this personally, but it's your job now; it's your responsibility, and so whoever was sitting in that chair is going to hear the same thing from members of this committee about your obligation to these children.

These aren't statistics. This was a child who was full of promise like every child, and the system let this happen to this child; and I see from your background that you have concerns about people in these lower economic situations. That's where I come from, and I identify with Deamonte, so that's why I will not give you or any witness who comes from the administration any wiggle room on this question. You will not have it. Just know that.

You know, with all due respect—because you know what? A child died. Now, I want—one of the significant reforms that could, in theory, increase the number of children who receive some preventative dental services is allowing pediatricians to apply fluoride varnishes. However, this subcommittee has heard that the administrative barriers to reimbursement for providing those services are discouraging doctors from doing it. My staff has received this correspondence from the Maryland Chapter of the American Academy of Pediatrics on this topic, and I ask unanimous consent to put this in the record.

[The information referred to follows:]

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Maryland Chapter

October 7, 2009

Dennis Kucinich, Chairman
Domestic Policy Subcommittee
U.S. House Committee on Oversight and Government Reform
B349-B Rayburn Bldg
Washington, DC 20515

Dear Chairman Kucinich:

The tragedy in Maryland of Diamonte Driver is well known to you. As we have discussed he is unfortunately the poster child for "Health Insurance not equating to access to healthcare." His death from a dental abscess occurred while he was covered by Maryland Medicaid. Dental care while covered under the Medicaid program was underfunded to such an extent that providers were unwilling to see these youngsters. In an attempt to correct this problem and enhance dental care for our youngsters, Maryland Medicaid increased the reimbursement for regular dental services and embarked on a new program to expand the number and type of healthcare providers available to render preventative dental services. The program is well intended and if widely implemented will make a significant impact on dental health in our pediatric population. However, the vendor hired by the health department has elected to pay only those providers who submit claims on dental claim forms. The office management systems in medical provider offices have no capacity to submit or track dental claim forms. This has resulted in physicians failing to enter the program.

During a recent meeting of our Academy a straw poll revealed a number of physicians who have received the training but have not rendered the service due to the added complexity of billing and tracking reimbursement. While the vendor has established a website for claims submission, this requires a dedicated individual to batch bill a single vendor for a single service. It would be far more efficient for the vendor to adapt their system to accept billing via a medical claim, thereby reducing the complexity of reimbursement for hundreds of providers. It also must be pointed out that medical providers have been mandated to provide billing to all agencies (public and private) on the standard CMS1500 format. This change for Medicaid is contrary to ongoing standards and not supported by regulations. A change on behalf of the dental intermediary could potentially improve the dental health of thousands of Maryland's children.

We sincerely appreciate your efforts and continuing interest in improving the health and well being of our children.

Sincerely,

Virginia Keane, MD

Virginia Keane, MD
President, MD Chapter
American Academy of Pediatrics

Melvin Stern, MD

Melvin S. Stern, MD
MD Chapter, American Academy of Pediatrics
Legislative Chair

744 Dulaney Valley Road, Suite 12, Baltimore, MD 21204
Phone: 410-828-9526 Fax: 410-828-9527 E-Mail: kim@mdaap.org

Mr. KUCINICH. Can you do anything about streamlining reimbursement for this procedure?

Ms. MANN. We do—thank you.

The Medicaid program does—will—does already in many States reimburse many pediatricians for providing sealants, and if there's any question that States have about their ability to claim Medicaid reimbursement for that procedure, we can certainly clarify that immediately.

Mr. KUCINICH. Great. If you'd study that letter, it would be very helpful, and maybe you could respond to it and send us a copy.

Ms. MANN. I would be glad to do that.

Mr. KUCINICH. In a letter to the subcommittee, Dr. James Crall, who has testified before us on two occasions, recommends, "A uniform program oversight and performance assessment regardless of State of residence."

I ask unanimous consent to insert the entire text of Dr. Crall's correspondence into the record.

[The information referred to follows:]

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA

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NATIONAL ORAL HEALTH POLICY CENTER
10990 Wilshire Blvd., Suite 9000
LOS ANGELES, CA 90024

December 15, 2008

The Honorable Dennis J. Kucinich
Chairman, Domestic Policy Subcommittee
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Kucinich:

This letter is in response to a request from Domestic Policy Subcommittee staff for my thoughts on the matter of priorities for improving dental care for U.S. children and programs/policies that CMS should pursue. I will divide my comments into two sections: short-term priorities within the current Medicaid policy/program framework and broader priorities that might be incorporated into more fundamental reforms.

Short-term Priorities within the Existing Medicaid Policy/Program Framework

1. Greater Federal Direction and Oversight of State Medicaid/EPSDT Dental Programs

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of federal Medicaid statutes outline a fundamentally sound framework for providing dental services for children enrolled in Medicaid. However, Congress and the Centers for Medicare and Medicaid Services (CMS) have not provided the level of direction (e.g., regulations) and oversight (e.g., State program monitoring) necessary to ensure that EPSDT statutes are properly and consistently implemented. Recommended priorities for CMS include:

- Emphasize to State Medicaid program officials and policy makers the importance of adequate Medicaid dental program financing and reimbursement and use of contemporary program administration practices (including contracting with reputable commercial dental plans) to ensure adequate Medicaid participation by dentists and access to care for Medicaid beneficiaries.
- Ensure that a knowledgeable dentist is actively involved in the review and approval of State Medicaid plan provisions that relate to EPSDT dental services and in State dental programs oversight.
- Ensure that all State Medicaid/EPSDT programs develop and maintain dental periodicity schedules that are consistent with contemporary recommendations for quality pediatric dental care, and that these schedules are used to evaluate Medicaid/EPSDT dental program performance.
- Continue to support the work of the CMS Dental Technical Advisory Group (TAG) and ensure broad dissemination of the TAG's recommendations.

- Support the creation and work of a Medicaid dental program quality initiative to develop relevant information for Medicaid program officials and policy makers, and to ensure that Medicaid/EPSDT beneficiaries have access to dental care that is consistent with contemporary professional guidelines.
- Restore sections of the CMS Guide to Children's Dental Care in Medicaid concerning financing/reimbursement and the importance early and ongoing care for Medicaid/EPSDT beneficiaries by way of quality dental homes.

2. Enhanced Federal Match for State Medicaid Dental Programs

The current economic situation is placing extraordinary demands on State budget makers. Despite growing recognition of the extent of chronic under-funding of State Medicaid dental programs, States need additional support from the federal government during these trying economic times. Increasing the level of federal match (FMAP) for Medicaid/EPSDT dental services could serve as a significant catalyst for State Medicaid/EPSDT dental program improvements.

Priorities within the Context of Medicaid or Healthcare Reform

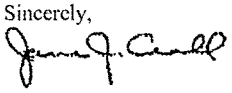
It can be argued that a considerable portion of the variability and chronic problems related to Medicaid dental program performance stem from the fundamental structure of the program -- in particular, the extent to which States control elements related to eligibility, program financing/budget allocations, provider payment levels, program administration and performance monitoring. Efforts to overcome these impediments have seen intermittent and achieved variable, modest and often short-lived success, generally during periods of good economic times or as a result of litigation in federal courts.

Alternatives to the strategy of implementing the priority recommendations outlined in the previous section within the current statutory/regulatory framework for Medicaid center on developing a new policy/program framework for Medicaid, either along the lines of Medicare or as part of more comprehensive healthcare reform initiatives. Although the details of such a strategy extend far beyond the scope of this letter, I would advocate for a number of principles within the context of whatever broad parameters or structure might evolve, specifically:

- Uniform eligibility and benefits regardless of State of residence of the beneficiary
- Uniform benefits regardless of State of residence
- Adequate financing to ensure reasonable payments for services
- Uniform program oversight and performance assessment regardless of State of residence
- Incentives for quality/performance improvement.

Thank you for the opportunity to provide these recommendations, and for your commitment to improving dental care for America's disadvantaged children.

Sincerely,



James J. Crall, DDS, ScD

Mr. KUCINICH. Ms. Mann, what can CMS do to fix the patchwork of oversight at the State level and to create a uniform system of oversight and assessment.

Ms. MANN. I think we can do a uniform system of assessment, Chairman. I think that the responses aren't uniform because the problems aren't uniform, and that's—if I could wave the wand and get that 66 percent and make it all happen by doing reviews tomorrow, I would do that. We don't have providers in many States and in many parts of the country that are willing to take Medicaid beneficiaries. We have a participation rate—a utilization rate in private health insurance of about 59 percent right now. We've got a multitude of problems in terms of getting oral health care to children both in and outside of the public systems. It is not an overnight problem.

We will commit, and we are committed to doing everything we can to make the Medicaid program work for every child and to make sure that dental care is there; but it is a multi-pronged problem, and I don't say that to try and get around our responsibilities. I say that to say that we're rolling up our sleeves, and it is not a simple solution. If I could do the oversight of 50 States tomorrow and say that would solve it, I would do the oversight of 50 States tomorrow. It won't solve it, but it will get us farther along, and we're willing to do that, of course, and to be as aggressive as we can.

Mr. KUCINICH. I think the watch words would be "corrective action" here, wherever there is action to be taken, that you don't stand by and figure they'll solve their own problems.

Ms. MANN. I agree. I agree. But when we have States come to us and say they don't have a dental provider within, you know, five counties of their State, corrective action plans won't get the child the dental care.

Mr. KUCINICH. But Deamonte Driver died. He had a provider, all right.

Ms. MANN. You're absolutely right, and that would have been a very different story. That's exactly right.

Mr. KUCINICH. So we understand that there are certain circumstances where you have to become involved in encouraging States with respect to their—to provider networks, but there are areas where they have providers, and we're wondering about corrective action in those areas.

Now, Dr. Crall's letter also recommends uniform eligibility and benefits regardless of State of residency.

Could you tell us what challenges CMS faces to creating such a system?

Ms. MANN. In the Medicaid program, actually, there is uniform benefit eligibility for children. That is the EPSDT program, and it is the guarantee that every child get that uniform eligibility, which is, simply stated, all the medical care that they need, that's deemed necessary. So we have a lot of variations for adults in Medicaid but not for children.

The question is do we get it enforced, and do we have providers taking the children, and do families know about the availability; and that's why we're setting up this listening session and doing this EPSDT work group. We have a problem beyond oral health.

We have a larger problem making sure that EPSDT benefit is observed for every child in the Medicaid program.

Mr. KUCINICH. Thank you very much.

Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

Just a couple of basics I was curious about.

What is the average time a child is enrolled in Medicaid?

Ms. MANN. Generally, in any given year, about 9 months.

Mr. JORDAN. So they're in 9 months, out? I mean, is there a back-and-forth a lot? Just tell me the typical scenario.

Ms. MANN. There's a fair amount of back and forth. If you look at——

Mr. JORDAN. Over their lifetime, what is the average? I mean, the lifetime of the child from 0 to 18. What's their lifetime?

Ms. MANN. I don't know. Over the lifetime, if you look at a cohort of uninsured children, about a third of them have actually been on Medicaid in the last year or so. So there's a lot of turning in and out, and one of the important advances, I think, that we can do to help children get access to care is to keep that coverage continuous.

Mr. JORDAN. But my point is—so some of these kids who aren't getting coverage—I mean do your numbers account for this one-third we've determined that are getting the dental care? Is it because—could they be, in fact, moving out of Medicaid and getting care from a private—you know, a private source?

Ms. MANN. They could be moving out of care and getting care from private sources. They could be moving out of coverage in Medicaid and simply being uninsured, but not have a card to then go to the dentist; and for Medicaid patients, it's probably more the latter, but it could be either.

Mr. JORDAN. What's the percentage of eligible Medicaid children, the percentage who are eligible who aren't enrolled—or the number? Give me those numbers.

Ms. MANN. About 7 out of 10 of all uninsured children are eligible for either Medicaid or CHIP but not enrolled. Some have been enrolled in the past, but they've been churned through the program; but at any given time, about 7 out of 10 of eligible children—of uninsured children—could be enrolled through either Medicaid or CHIP. They're eligible.

Mr. JORDAN. OK.

Ms. MANN. That's why enrollment and continuous enrollment is a very important piece of the quality puzzle.

Mr. JORDAN. OK. OK.

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the gentleman.

The Chair recognizes Mr. Cummings.

Mr. CUMMINGS. Ms. Mann, the Government Accountability Office reported in September 2008 that the extent of dental disease in children had not decreased between 1994–2005, which means that kids were estimated to have untreated tooth decay. Information from that report 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 insurance—and you know, you know the stats—how much funding was lacking and what was the cause of unavailability, do you know?

In other words, what is CMS doing about the urgency of the need for the treatment of these children, some of whom may be adults now, and how are we addressing that? How do you plan to address that?

Ms. MANN. I'm sorry. The treatment of adults?

Mr. CUMMINGS. Yes.

Ms. MANN. In the Medicaid program under Federal law, coverage of dental services for adults is optional with the States, and as you look through what's going on in the States now and during a recession, it's one of the first set of benefits that States will cut out if they're looking to reduce their Medicaid budgets, so it is not a requirement nor is the standard, even once they cover an adult in Medicaid, nearly as robust as the standard is for children.

Mr. CUMMINGS. Ms. Iritani, you were talking about barriers and what the State folks said were the barriers, and you said that one of the things that was talked about the most was the failure to make appointments; is that right?

Ms. IRITANI. That's correct.

Mr. CUMMINGS. Did you all have any recommendations as to how to deal with that?

Ms. IRITANI. Our recommendations aimed at CMS were to conduct more reviews of the States with low access rates. They—CMS' reviews looked at a number of different access-related problems, including inadequate provider networks, and we also advised CMS that they should take action to ensure that any State found with an inadequate provider network to corrective action.

Mr. CUMMINGS. Ms. Mann, you know, when Ms. Iritani was talking about this earlier, I was thinking about how important it is that parents understand the relationship between teeth and the rest of the body. I think a parent—any parent wants their kid to be healthy, but I don't think a lot of parents have a clue of the relationship between the teeth and the body; and I'm just wondering did you have any thoughts on that with regard to making sure that we get that information out there?

We—well, I was the author of an amendment to SCHIP where we were able to do some things in that regard, but I'm just wondering: Is that on your list? Because, you know, that's one of the things that—it might cost some money getting the information out, but the benefits would be phenomenal compared to the money that we put out because then you'd have all these agents call parents, who—you know, it's just like I think of a parent who thought that their kid had a fever. They would do everything in their power to address that when, certainly, tooth decay could lead to something far worse than a fever, and so I'm just wondering what your feeling is on that.

Ms. MANN. I think you're absolutely right. Prevention is a key to moving forward. There is a provision—and perhaps this is the one you're referring to—in the CHIP legislation that requires education for pregnant women and parents of newborns, and we are working on developing an education campaign. We're partnering—we plan on partnering with the Centers for Disease Control. We've

been reaching out to some of the philanthropic organizations around the country and to look at other mechanisms to get information out to pregnant women and to newborns about what they can do.

We also find that the dental utilization rate is much lower for adolescents, and I think that's also a lack of information about how important dental care is for teenagers, so I think coming up with a campaign that helps to provide some information to parents as well as to teenagers, themselves, will be really important.

Mr. CUMMINGS. Can you assume—give us a deadline on that, give us some type of timetable on that since it's such an important and potentially beneficial and cost-saving thing? We want to really followup on that, and I have a tremendous personal interest in that, all right?

Ms. MANN. I would be glad to provide you with a plan and a timetable attached to it.

Mr. CUMMINGS. Very well.

Thank you, Mr. Chairman.

Mr. KUCINICH. I thank the witness for her responsiveness and the GAO for their report. This committee appreciates your attendance, and we will be in touch with you regarding our next meeting. Thank you very much.

The first panel is dismissed. We will now go to the second panel.

While our staff is concluding its work, this is the Domestic Policy Subcommittee of Oversight and Government Reform. Today is Wednesday, October 7, 2009. The title of today's hearing is "Medicaid's Efforts to Reform since the Preventable Death of Deamonte Driver."

We have heard from witnesses from the GAO and also from the new director for the Center for Medicaid and State Operations. We are fortunate to have an equally outstanding group of witnesses on our second panel.

Burton L. Edelstein, who is a D.D.S. and an M.P.H., is a professor of Clinical Dentistry and Clinical Health Policy and Management at Columbia University's College of Dental Medicine and Mailman School of Public Health. He is founding director and board Chair of the Children's Dental Health Project—a D.C.-based nonprofit policy and strategic consulting organization that advances policies to improve children's oral health.

Mary G. McIntyre, M.D. and M.P.H., is medical director of the Office of Clinical Standards and Quality for the Alabama Medicaid Agency. She received an award from the Alabama Dental Association's House of Delegates in 2004 for outstanding leadership and championing the cause for improved oral health for Alabama's children. Dr. McIntyre served as chairman of the Robert Wood Johnson Foundation National Advisory Committee State Action for Oral Health Access.

Joel Berg, D.D.S. and M.S., is professor and Lloyd and Kay Chapman Chair of the Lloyd and Kay Chapman Chair for Oral Health. He serves as the Chair of the Department of Pediatric Dentistry at the University of Washington and dental director at Seattle's Children's Hospital. He is author of a multitude of manuscripts, abstracts and book chapters regarding a variety of subjects, including restorative materials for children and other work related

to bio materials and is coeditor of a textbook on early childhood oral health.

We have Doctor—or Frank Catalanotto; is that right?

Dr. CATALANOTTO. Yes.

Mr. KUCINICH. D.M.D. He is professor and Chair of the Department of Community Dentistry and Behavioral Sciences, University of Florida College of Dentistry. He has chaired a number of committees in the American Academy of Pediatric Dentistry. He has served on the editorial board of the Academy's journal, "Pediatric Dentistry." In addition, he was a member of the National Affairs Committee of the American Association for Dental Research from 1989 to 1995. This committee works with the Federal congressional delegation to increase funding for dental research, particularly for the National Institute of Dental Research. He is currently a member of the Legislative Affairs Committee of the American Dental Education Association, which advises and lobbies on Federal policies and appropriations related to dental education and practice.

I want to thank all of you for appearing before our subcommittee. It's the policy of our Subcommittee on Domestic Policy of the Committee of 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. Thank you very much.

Let the record reflect that each of the witnesses answered in the affirmative.

As with panel one, I would ask each witness to give an oral summary of his or her testimony. Please keep this summary under 5 minutes in duration, and your complete statement will be included in the hearing record.

Again, thanks to each and every one of the witnesses for being here. I would like Dr. Edelstein to begin as the first witness on this panel.

You may proceed, sir.

STATEMENTS OF BURTON EDELSTEIN, D.D.S., M.P.H., CHAIR, CHILDREN'S DENTAL HEALTH PROJECT; MARY McINTYRE, M.D., M.P.H., MEDICAL DIRECTOR, OFFICE OF CLINICAL STANDARDS AND QUALITY, ALABAMA MEDICAID AGENCY; JOEL BERG, D.D.S., M.S., CHAIR, DEPARTMENT OF PEDIATRIC DENTISTRY, UNIVERSITY OF WASHINGTON; AND FRANK CATALANOTTO, D.M.D., PROFESSOR AND CHAIR, DEPARTMENT OF COMMUNITY DENTISTRY AND BEHAVIORAL SCIENCES, UNIVERSITY OF FLORIDA, COLLEGE OF DENTISTRY, REPRESENTING AMERICAN DENTAL EDUCATION ASSOCIATION

STATEMENT OF BURTON EDELSTEIN

Dr. EDELSTEIN. Thank you, Mr. Chairman, Ranking Member Jordan and members of the subcommittee. I appreciate the opportunity to come before you today to testify about the Federal Government's role and responsibilities in ensuring that children in Medicaid have access to the dental care that is entitled to them by Federal law.

I am Dr. Burton Edelstein, Columbia University professor and Chair of Children's Dental Health Project here in D.C.

The founding of the Children's Dental Health Project in 1997 was a direct response to congressional enactment of the State Child Health Insurance Program because I, as a pediatric dentist who treated children on a daily basis, was shocked by the lack of attention that in 1997 was given to children's oral health. It was not until the death of Deamonte Driver that so much attention has been brought to this issue, and the subsequent work by this subcommittee and others has ensured that policymaking simply, as you've demonstrated today, will not leave this issue to fester any longer.

The result of the attention that you have brought to this issue led to significant improvements in provisions in CHIP through CHIPRA. I commend the chairman and the committee on this issue, and I cannot think of a better example of how far we have come than to have Cindy Mann as the CMSO director with her personal commitment to children and to children's oral health.

Clearly, Mr. Cummings, I agree with the statement you made earlier that we may need to do something different, and I think we need to explore the limits of what CMS can and cannot do as well as what it can do in partnership with other agencies across the Federal Government.

Clearly, all of the progress that has been made has still left a number of challenges. So, 2½ years after the subcommittee launched its investigation, we still have Deamonte Drivers out there, and we need to consider some of the more structural and fundamental issues that limit the access to health care.

At the time that CDHP was founded, subsequent to SCHIP, the vast majority of advocacy on behalf of oral health for children was made by organizations of dentists. This makes sense, of course, because it's dentists who are on the front line of providing care to children. However, dentists, parents and the program all both contribute to and can help solve the woeful inadequacy that you've highlighted today.

When asked about how to improve the program, dentist organizations typically respond with the very items that we heard featured today: low payments, complex paperwork and noncompliant patients. Unfortunately, we have seen in States across the Nation that addressing these three issues alone—and many States have taken significant actions on these three issues—has not led to the kinds of increases that we would hope for. Research has shown that increasing reimbursement absolutely is a necessary but not a sufficient condition for improving dental access.

For example, an analysis done by the California Health Care Foundation in four States shows that raising reimbursements did significantly kick up the percentage of kids receiving care but only from a quarter of children to a third, which is that level that we're stagnating at today.

Studies currently underway by my research group at Columbia University indicate that, during the period 1999 to 2006, 41 States did increase fees; 25 showed no increase in utilization primarily because those increases didn't bring them into the market. However, amongst the 25 that did have an increase in both fees and utiliza-

tion, about half—13—still only reached a level of 33 percent or more. Overall, in 2006, 20 of our States still provided care to fewer than one-third, and no State has broken the 50 percent level yet. A variety of factors contribute to this problem, which I've detailed further in my written testimony.

Based on the complexity of this issue, CDHP has advocated for a holistic approach to improving children's oral health—an approach that combines both public health and patient-focused interventions. In my written testimony, I lay out solutions that can be pursued by a variety of agencies—by CDC, NIH, HRSA, WIC, Head Start, AHRQ, as well as CMS.

CMS, of course, plays a particularly pivotal role because it is both the funder and the regulator of so much of this care, and the suggestions that we've made fall under the three categories that have been featured already today—leadership, technical assistance and oversight—which I believe CMS is now fully committed to pursue. My colleagues and I at the Children's Dental Health Project look forward to continuing to work with this committee, with CMS and with all who are concerned about dental care for Medicaid beneficiaries.

When CDHP was founded, we called it "a project." We specifically called it "a project" with the realization that the problem we're addressing is solvable. Tooth decay in children is preventable. The irony is that we're putting so much effort into chasing after disease that can be prevented in the first place.

I look forward to continuing to work with you and with all who care about children's oral health to solve this problem. That concludes my testimony. I look forward to your questions.

Mr. KUCINICH. Thank you very much, Dr. Edelstein.

[The prepared statement of Dr. Edelstein follows:]

Testimony of Burton L. Edelstein, DDS, MPH

Professor of Dentistry and Health Policy & Management
Columbia University

Chairman of the Board
Children's Dental Health Project

Domestic Policy Subcommittee
Oversight and Government Reform Committee
U.S. House of Representatives

October 7, 2009, 2 p.m.
2154 Rayburn House Office Building

Mr. Chairman, Ranking Member Jordan and Members of the Subcommittee,

I appreciate the opportunity to come before you today to testify about the federal government's roles and responsibilities in ensuring that children in Medicaid have access to the dental care that is entitled to them by federal law. I am Dr. Burton Edelstein, professor of dentistry and health policy at Columbia University and Founding Chair of the Children's Dental Health Project (CDHP), a DC-based independent non-profit organization committed to improving children's access to oral health.

I founded CDHP in 1997 in response to Congressional enactment of the State Children's Health Insurance Program (SCHIP). As a Robert Wood Johnson Foundation Health Policy Fellow in the office of Senate Minority Leader Tom Daschle, I had the opportunity to work on the SCHIP legislation throughout its development and was shocked by the lack of attention that children's oral health received at the time. The only mention of oral health in the legislation was the option that states were given to provide children with dental care. CDHP's original goal was to encourage states to adopt this optional dental benefit for children. Ultimately all states did so.

At the time of SCHIP enactment, Key Members of Congress and their staff were unaware that dental caries remains the single most prevalent chronic disease of U.S. children, five times more common than asthma, as later reported by the Surgeon General. It was not known that tooth decay affects nearly half of all children before they enter kindergarten, as later evidenced by CDC data. Congress was also unaware that tooth decay, when severe, causes children impairments in eating, speaking, and attending to school. This Subcommittee and others had not yet investigated the tragic and avoidable death of 12-year-old Deamonte Driver who succumbed to complications of an ordinary dental abscess.

By time Congress passed Children's Health Insurance Program Reauthorization Act (CHIPRA) earlier this year and took up Healthcare Reform in the Spring, work by this Subcommittee and others had insured that policymakers in Washington are finally demonstrating a clear understanding of the importance of oral health. I commend the Chairman for his leadership on this issue.

Because Congress now understands the importance of oral health, we have achieved key victories for children in CHIPRA. As in Medicaid, CHIP now requires comprehensive dental coverage. Parents of newborns whose delivery was paid by Medicaid and CHIP will now receive information on how to prevent early childhood caries before they leave the hospital. Reporting and accountability standards are now raised in both Medicaid and CHIP. And parents are now able to identify those few dentists who do participate in Medicaid through the federal "InsureKidsNow" website and telephone resource. A newly commissioned GAO study will further explore why so few dentists care for children in Medicaid and will address the potential for new midlevel dental providers to expand access.

This momentum has now led to significant gains in draft healthcare reform legislation. To date, all five committees of jurisdiction in the U.S. House of Representatives and U.S. Senate have included a mandatory pediatric dental benefit in the essential benefits package. Further,

Representative G.K. Butterfield of North Carolina has secured an amendment in the Energy and Commerce Committee that would require the Secretary of Health and Human Services to report to Congress after one year of enactment on the need and cost of including dental coverage for adults in the essential benefits package. We believe this is an excellent first step in addressing the extreme unmet need for dental care in the adult population that currently lacks dental coverage.

We were also extremely pleased to see a key CDHP-supported amendment offered by Representatives Diana Degette of Colorado, John Sarbanes of Maryland and Jerry McNerney of California that adds an oral health expert to any health benefits advisory committee. Because of the historic separation of oral health delivery and financing from the traditional medical system, the importance of oral health is often overlooked. For this reason, the inclusion of an oral health expert on any health benefits advisory committee will be critical.

Finally, we are pleased to see the provisions in both the House Tri-Committee and Senate Health, Education, Labor and Pensions (HELP) Committee bills that expand training programs for dentists and fund demonstration grants for midlevel providers. The Senate HELP bill also includes several critical public health provisions that would impact oral health. It creates a public education campaign; demonstration grants for dental caries management; school-based dental sealant programs in all 50 states; allows school-based health centers to use funds for dental programs; and authorizes CDC grants to improve oral health.

Yet for all this progress, great challenges still remain. The most recent GAO report under consideration by this Subcommittee today reports that dental care for children in Medicaid remains wholly inadequate despite a number of efforts by both CMS and State Medicaid authorities. To quote the report, "Access rates remain low… [and] longstanding barriers to children's access to dental services and barriers to dentists' participation in Medicaid hinder further improvement." As a result of these barriers, only a quarter of children in Medicaid saw a dentist in 2000 and today only a third obtains dental care - leaving the majority of child beneficiaries still with unmet dental needs.

The level of attention paid to children's oral health in CHIPRA and in healthcare reform needs to extend to ensuring that Medicaid is made to work for children, their families, and their dentists. Two and a half years after this Subcommittee first launched its investigation, children like Deamonte Driver still live among us and still suffer needlessly from dental conditions that are fundamentally preventable.

At the time that I founded CDHP, the vast majority of advocacy on behalf of oral health was conducted by organizations representing dentists. This makes sense, as dentists are on the front lines of providing dental care. However, dentists – like parents and program officials – both contribute to and can help solve the woeful inadequacy of dental care for children in Medicaid. When asked how to improve access to care, groups representing dentists have long advocated for a policy agenda that can be framed into three main categories: better payment, streamlined paperwork and improved patient compliance – with payment being the most emphasized.

Unfortunately, we have seen in states across the nation that addressing these three issues does not lead to the hoped for increase in access or utilization.

Raising reimbursement rates to appropriate levels so that payments represent more than governmental subsides to charitable care is a necessary but not sufficient solution to improving dental access. For example, an analysis by the California Healthcare Foundation of four state's experience in raising dental reimbursements reported that substantial fee improvements did increase utilization - but only from an average of 24% to an average of 32% after two years.

More detailed studies currently underway by my research group at Columbia University substantiate that during the period 1999-2006, 41 states reported fee increases but only 25 of these states also showed an increase in utilization, likely because the others' increases were insufficient. No state experienced improvements in utilization if they did not also raise fees at some time during this period and many of these state reforms also included reductions in paperwork and improved client assistance in making and keeping appointments.

Among the 25 states whose fee increases are associated with utilization increases, however, only 13 reached utilization levels of 33% or more. Overall, by 2006, 20 states still provided dental care to fewer than one-third of enrolled children and no state reached more than 45% of children. While these low treatment rates may suggest that parents fail to seek care when available, that is an unlikely explanation as the majority of children in Medicaid obtain one or more primary medical care visits in a year.

Notable in the Columbia study were some states, particularly those that are rural or frontier, in which utilization rates exceed the national average despite lower than average 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.

<u>If we know that payment, paperwork and patient compliance are not the only answers, the question then becomes, why aren't dentists seeing Medicaid patients?</u>

Contributing to the problem of dentist availability for children in Medicaid are:

- a relative decline in the numbers of dentists as the profession ages, the U.S. population expands, and the training of new dentists fails to keep up;
- the advent of elective, cosmetic dentistry that has crowded out some basic reparative capacity in the dental delivery systems;
- geographic, sociocultural, and language dislocations between primary care dentists and child populations with greatest needs. (The 2008 American Dental Association Medicaid Symposium noted that "participants felt that dental students and many current practitioners have not been adequately exposed to underserved populations during their training. Many are misinformed about the ... Medicaid population...leading to dentists unknowingly being culturally insensitive.");
- the recession's pressure on state government to control Medicaid expenditures as Medicaid is a countercyclical program that faces greatest demands even as state revenues decline;

- the numbers of states that put their dental vendors at financial risk for increases in utilization since profits decline when utilization increases. (This problem was clearly evidenced in Georgia when vendors cut providers from their networks to ward off utilization increases.);
- the need for greater training of new dentists in the care of children and underserved populations. (The American Dental Education Association's graduating dental student survey for the class of 2006 reports that 1-in-9 new graduates feel less than fully prepared to treat children, 1-in-6 to provide oral health care to a diverse society, and 1-in-5 to provide oral health care in rural areas.)
- unwillingness of some dentists to treat Medicaid beneficiaries. (The peer reviewed dental literature substantiates negative attitudes toward Medicaid and its beneficiaries. The ADA Medicaid Symposium reported that "There is a definite fear among some dentists that their private practices will be overrun by Medicaid patients.)";
- the lack of qualified midlevel primary care dental providers who could offer basic reparative services to children. (Minnesota this year was the first state to authorize "dental therapists" to provide primary dental care to underserved populations, an approach previously adopted by many other countries.);
- too much dental disease is not being prevented because validated protocols to manage childhood caries as a chronic disease are still in development and the dental profession has yet to widely utilize health educators, psychologists, behaviorists, community health workers and others who are trained to help families improve their day-to-day oral health behaviors.

Given these factors, CDHP has advocated for a holistic approach to improving children's oral health, an approach that includes both public health and patient-focused interventions. Action is needed across the federal government.

- The Centers for Disease Control and Prevention (CDC) – already so effective in promoting community water fluoridation and school based dental sealant programs - can play a far greater role in educating the public about risks for and prevention of early childhood tooth decay.
- The National Institutes of Health (NIH) – which has supported nearly a decade of research in eliminating oral health disparities in children – can encourage adoption of its findings by the professions and the public.
- The Health Resources and Services Administration (HRSA) – which has so strongly promoted children's oral health through prevention, direct care, workforce development, and health information technology – can, with expanded support from Congress, leverage its programs more widely and play a major role in developing new midlevel dental providers.
- The Agency for Healthcare Research and Quality – which has substantiated oral healthcare utilization through its MEPS analyses – can invest far more substantially in improving dental systems of care.
- Head Start and WIC – traditional partners in childhood oral health promotion - can engage in active demonstrations of best practices to improve children's dental care.
- And CMS – the subject of this hearing - holds plays a particularly powerful role as a funder and regulator of care for underserved children.

Because the purpose of this hearing is to discuss what the Centers for Medicare and Medicaid Services (CMS) can do, I have organized our recommendations under the broad categories previously suggested to this Subcommittee of *leadership, technical assistance,* and *oversight.*

Leadership: CMS can:

- Promote the reestablishment of a DHHS Department-wide Oral Health Initiative led by an effective coordinator in the Office of the Secretary.
- Reestablish Oral Health Leadership teams in each of the DHHS Regional Offices comprised of experts from CMS, HRSA, and the dental profession.
- Utilize its communications, regulatory, and demonstration authorities to develop and promote best practices that address core barriers to dental care for children in Medicaid.
- Hold states publicly accountable for meeting existing EPSDT program requirements.
- Prioritize dental program performance when reviewing state programs.

Technical Assistance: CMS can:

- Encourage innovation and experimentation through demonstrations with a particular emphasis on disease prevention and management.
- Feature successful interventions and provide states with practical tools for their replication.
- Ensure that quality measures being crafted under CHIPRA can be effectively implemented and tracked and are used for program improvement.
- Maximize opportunities created in CHIPRA to provide information to beneficiaries' families about the dental benefit, promote the "dental wrap," encourage contracting between FQHCs and private dentists, and maximize the potential for early parental education on caries prevention.

Oversight: CMS can:

- Continue exerting pressure on the states to meet existing EPSDT dental requirements.
- Establish systems to ensure states meet CHIPRA dental requirements.
- Improve the timeliness and completeness of Medicaid 416 reporting.
- Require states to correct existing shortcomings within the www.insurekidsnow.gov web site.

My colleagues and I at the Children's Dental Health Project look forward to working closely with CMS on actions that it can take to improve the oral health and dental care of Medicaid beneficiaries.

When I founded CDHP, I called it a "project" to reflect the reality that childhood tooth decay is a solvable problem. Congress, federal agencies, dental authorities, and child advocates can work together toward eradicating this scourge by identifying those at greatest risk early in their lives, providing families with the tools to manage that risk, ensuring ready access for all children to comprehensive prevention-oriented dental care, and allocating our resources where the needs are greatest. I look forward to continuing to work with this Subcommittee, CMS, and all who care about children's oral health to achieve the goal of healthier children.

That concludes my testimony. I am happy to answer any questions that the Committee may have.

Thank you.

Mr. KUCINICH. Dr. McIntyre, you may proceed for 5 minutes.

STATEMENT OF MARY McINTYRE

Dr. MCINTYRE. Mr. Chairman, Ranking Member Jordan and members of the subcommittee, thank you for the opportunity to speak on behalf of the Alabama Medicaid Agency and the population that we serve.

My name is Dr. Mary McIntyre, and I serve as medical director, and I'm not a dentist, but a physician, board certified in public health and general preventative medicine. I appreciate the opportunity to testify before you today on the progress that we have made. This has been a 10-plus-year journey, and it isn't over yet. The vision statement for our State Oral Health Coalition and for our Smile Alabama! initiative is to ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well-being of the child.

I have been asked to address the programmatic aspects of the Smile Alabama! initiative that have, No. 1, improved access to and the utilization of pediatric dental services and, No. 2, increased provider enrollment and participation.

More than 10 years ago, the Alabama Medicaid Agency recognized that significant growth in the number of children eligible for Medicaid dental services and a decrease in dental provider participation in the Medicaid dental program had combined to create a dental access crisis. The dental utilization rate in 1998 was approximately 25 percent, due largely to the low number of Medicaid participating providers but also because of the widespread belief that preventative dental care for children, especially very young children, was unimportant. Providers complained of low reimbursement rates, uncooperative patients and families, and a cumbersome claims filing process.

A decade later, Alabama Medicaid's dental utilization is up by more than 62 percent, and there has been a 216 percent increase in the number of dentists who see more than 100 patients per year. There is greater public awareness that good oral health is essential to overall health.

What made this possible is the collective determination of many people in both the public and the private sectors to find solutions and the willingness of dental providers, State leaders and others to implement steps necessary to bring about meaningful change.

While the initiative known as Smile Alabama! was the primary catalyst to this important public health achievement, there were several important milestones that laid the groundwork for its success. These include the formation of a dental task force, increases in the dental reimbursement rate, major claims processing changes, dental outreach efforts, formation of a public-private alliance, creation of an oral health strategic plan and policy leadership team, convening of two State dental summits, and finally, the successful funding and implementation of the Smile Alabama! initiative.

In February 2001, the Alabama Medicaid Agency received a grant of $250,000 to enhance dental outreach efforts through the Smile Alabama! initiative. Funding for the grant was provided

through the Robert Wood Johnson Foundation's 21st Century Challenge Fund—a component of the Southern Rural Access Program—and was matched by Federal, State and private funds to total more than $1 million.

In summary, the Smile Alabama! initiative was composed of four components—a dental reimbursement increase, claims processing simplification, patient outreach in education and provider outreach.

In conclusion, in order to improve access to and the utilization of oral health care services, a focus on prevention and early care is important. A multi-pronged approach must be taken for a complex multifaceted issue. Efforts must be ongoing. None of us want any child to suffer. I, personally, know what it is to be a child in severe pain from a dental abscess because my parents lacked the means to obtain care.

States are struggling to maintain services in the light of severe budget shortfalls. We are currently experiencing increased enrollment due to the present state of the economy, with shrinking budgets, while trying to increase utilization. These factors will limit our ability to push utilization up, and must be considered in any discussion surrounding finding the solution to the dental access issue.

It is important that everyone understand that improving the oral health status of this most vulnerable population will require an understanding of all of the factors that result in underutilization.

Thank you for this opportunity to speak today on behalf of the Alabama Medicaid Agency and the recipients that we serve.

Mr. KUCINICH. Thank you, Dr. McIntyre.

[The prepared statement of Dr. McIntyre follows:]

Testimony
Of
Mary G. McIntyre, MD, MPH
Medical Director, Alabama Medicaid Agency
Office of Clinical Standards and Quality

Domestic Policy Subcommittee
Oversight and Government Reform Committee
Wednesday, October 7, 2009
2154 Rayburn HOB – 2:00PM

Mr. Chairman and members of the Subcommittee,

Introduction

Thank you for the opportunity to speak on behalf of the Alabama Medicaid Agency and the population that we serve. My name is Dr. Mary McIntyre and I serve as Medical Director for the Alabama Medicaid Agency with lead responsibility for the Office of Clinical Standards and Quality. I am not a dentist but a physician, board certified in public health and general preventive medicine. I appreciate the opportunity to testify before you today on the progress that we have made to increase utilization of dental services for Medicaid eligible children. This has been a 10+ year journey for Alabama and it is not over yet. The vision statement for our state Oral Health Coalition and for our *Smile Alabama!* initiative is "To ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized promoting the total well-being of the child." This vision has driven the changes I will talk about today.

In previous hearings, you have heard about the lack of access to oral health care services for Medicaid children. These discussions have focused on access and availability to dental services and the CMS 416 and its limitations. I have been asked to address the programmatic aspects of our *Smile Alabama!* initiative that have 1) improved access to and utilization of pediatric dental services for Medicaid-eligible children; and 2) increased provider enrollment and participation.

More than 10 years ago, the Alabama Medicaid Agency recognized that significant growth in the number of children eligible for Medicaid dental services and decreasing dental provider participation in the Medicaid Dental Program had combined to create a dental access crisis in Alabama. The dental utilization rate in 1998 was approximately 25 percent, due largely to the low number of Medicaid-enrolled providers, but also because of the widespread belief that preventive dental care for children, especially very young children, was unimportant. Providers complained of low reimbursement rates, uncooperative patients and families, and a cumbersome claims filing process.

A decade later, Alabama Medicaid's dental utilization is up by 62 percent, and there has been a 216% increase in the number of dentists who see more than 100 patients per year. There is greater public awareness that good oral health is essential to overall health.

What made this possible is the collective determination of many people in both the public and private sectors to find solutions, and the willingness of dental providers, state leaders and others to implement the steps necessary to bring about meaningful change to improve access to and utilization of pediatric dental services for Medicaid-eligible children.

While the initiative known as *Smile Alabama!* was the primary catalyst to this important public health achievement, there were several important milestones that laid the groundwork for its success.

These include the formation of a dental task force, increases in dental reimbursement rates, major claims processing changes, dental outreach efforts, formation of a public/private alliance, creation of an Oral Health Strategic Plan and Policy Leadership Team, convening of two state Dental Summits, and finally, the successful funding and implementation of a Robert Wood Johnson Foundation grant for the *Smile Alabama!* initiative.

Dental Task Force

The Alabama Medicaid Agency contacted the Alabama Dental Association in November of 1997 seeking input and assistance in identifying dentists across the state, both Medicaid and non-Medicaid providers, to be appointed to a dental task force. The task force determined the major issues surrounding the dental program and then worked to address these issues.

Medicaid made the following recommended changes within the first 12 months of forming the task force:

- Simplified the prior authorization process. The criteria are now included in the Dental Provider Billing Manual. Procedures requiring prior authorization are also indicated in the manual.
- Added a number of previously non-covered dental procedures in order to include codes more consistent with current dental practice.
- Added two more years of coverage for dental sealants. Dental sealants are now covered for children ages 5 through 13 for tooth numbers 02, 03, 14, 15, 18, 19, 30, and 31.
- Clarified program limits with a revision of the Dental Provider Billing Manual.
- Provided Targeted Case Management (TCM) to dental providers.
- Increased dental rates.
- Removed prior authorization requirements from crown codes.

Dental Outreach Efforts

In addition to the changes listed above, the Medicaid Agency sought the assistance of the Alabama Department of Public Health and the University of Alabama at Birmingham Dental School to identify and improve access to dental services. Efforts to increase the number of providers by supplying information about the Medicaid dental program include:

- Addressing the University of Alabama at Birmingham Dental School's junior and senior/ graduating dental students.
- Attending the Alabama Dental Association, Alabama Dental Society and Academy of General Dentist's annual meetings to provide information on the dental program, provider enrollment and electronic claims submission.
- Assisting providers with denied claim issues.
- Addressing dental provider issues in the EDS Bulletin.
- Increasing EDS dental provider assistance.
- Notifying all enrolled dentists about changes in the program.
- Providing a Dental Rate Fee Sheet showing old and new rates.
- Making personal calls to every active dental provider to identify any claims issues and assist in addressing the identified problems.
- Providing dental Targeted Case Management to address the no-show issue identified in a series of surveys conducted.

The Alabama Medicaid Agency also formed an Outreach Work Group of Medicaid and EDS staff members to address the dental access problem and the need for recruiting dental providers. Initial efforts focused on retention of current providers and addressing their greatest concerns -- resolving claims problems and understanding why claims were denied.

These concerns were identified through a survey of Medicaid providers completed in April of 2000. After identifying dental providers who had discontinued seeing Medicaid recipients, the agency focused efforts on informing them about changes in the program, explaining the electronic claims submission process and providing enrollment information. The Outreach Work Group determined that important components of the dental recruitment plan would include continued guidance from the Dental Task Force for direction and content of recruitment efforts along with continued provider support in claim resolution and patient compliance

Dental Rate Increase

Through the Dental Task Force and surveys conducted of our state's dentists, many indicated that they were actually paying to see Medicaid recipients, that is, it cost them money to provide care since they were not able to cover their office overhead costs.

Surveys were conducted by the Agency and the Alabama Department of Public Health with assistance from the Alabama Dental Association which provided information as to how much rates would need to be increased for a dentist to see Medicaid recipients and about office capacity to handle new Medicaid dental patients.

The governor committed $2 million in new state dollars to the Alabama Medicaid Dental Program in 2000 for a total of $6.5 million for the dental rate increases. This initial rate increase allowed the Medicaid Dental Rates to be taken to 100% of the Blue Cross and Blue Shield of Alabama fee schedule allowing us to meet the market rates. This was seen as an enabling factor in that it was important to allow for adequate reimbursement of the services provided by our dental providers.

While the rate increase was a necessary component it alone was not felt to be sufficient to allow for the achievement of the goals established. This was documented by the results of the surveys which also identified additional issues to the low dental reimbursement rates. There were also initial delays in obtaining a dental rate increase and thus simplification of the claims processing was undertaken as the first component of the initiative to implement.

National Governors Association - Policy Academy on Oral Health

In October 2000, the State of Alabama was selected to participate in the NGA Center for Best Practices Policy Academy on Oral Health for state officials. The Alabama Medicaid Agency, acting as lead agency for the state, submitted a proposal and was selected to attend the first NGA Policy Academy.

The Alabama team established three major priorities; addressing workforce scope and shortage issues, increasing education in communities regarding the importance of oral health, and developing and implementing surveillance and monitoring process to assess oral health status within the state. This meeting gave us the impetus to begin the development of an oral health strategic plan for the state and to expand membership in the Dental Partners Workgroup while changing its name to the Oral Health Coalition of Alabama which continues to meet today.

The Oral Health Coalition has completed numerous action steps. Expansion of Resident Placement, use of auxiliary assistance that links back to dentists, and the use of alternative providers for education and prevention are examples of strategies identified and implemented. Educational efforts have included a statewide *Smile Alabama!* campaign, use of case managers to deliver oral health care education during prenatal visits, coordinating with local policy councils to develop and distribute educational materials, and developing an oral health fact sheet for legislators.

Dental Partners Workgroup (Now Oral Health Coalition of Alabama)

Formation of a public/private alliance was necessary to address the dental care issues in Alabama. Partners included representatives of the Alabama Dental Association, Alabama Department of Public Health, and the University of Alabama at Birmingham Dental School, the Office of Children's Affairs and Medicaid.

Oral Health Coalition of Alabama

The OHCA was created in the summer of 2001, merging the Dental Partners Work Group with expanded members to continue the work of the Alabama NGA Policy Academy Team's Strategic Plan that was later expanded by the participants of the Alabama Dental Summit. In Feb. 19,

2002, OCHA established three sub-groups to work on the priorities developed during the NGA Academy. Medicaid meets with this group at least quarterly. This group:

- Assists the state in disseminating information and building public awareness.
- Advises in the development, implementation and completion of the strategic oral health plan.
- Creates and reinforces relationships between key stakeholders to ensure the success of state efforts in improving oral health care in Alabama.

The three groups, Alabama Medicaid Dental Task Force, the Oral Health Coalition of Alabama and Alabama Oral Health Strategic Team (previously the AL NGA Policy Academy Team) continue to meet independently while coordinating activities to allow for synergy and more rapid institution of identified strategies. These three groups are convened and coordinated by the Alabama Medicaid Agency.

Alabama Dental Summits

The first Dental Summit on Dec. 6-7, 2001, brought together a diverse group of state and community leaders to focus on the barriers preventing Alabama children from accessing needed care. More than 70 participants identified issues and developed ideas for a specific plan of action. In workgroups the participants focused on four key concerns -- funding, education/awareness, surveillance and monitoring, and legislative-regulatory changes.

Leaders from the state's political, physician-dental, educational, religious, consumer, non-profit and government structure were joined by national government dental policy analysts and advocates from New York, California, Washington, D.C., and Colorado.

The second Dental Summit on Jan. 24, 2003, drew 49 local and national health, business, community and legislative leaders together to focus on ways to improve access to dental care for Alabama's children. The summit included presentations, panel discussions and other materials where the participants shared information on oral health issues. Networking among the professionals and experts was a very beneficial aspect of the coalition process. This summit provided evidence of a common goal for improving dental care in Alabama. The evaluations revealed that the summit was very informative; the participants enjoyed it and would like to continue their efforts to achieve good oral health for Alabama's children.

Smile Alabama! and the Alabama Medicaid Dental Program

In February 2001, the Alabama Medicaid Agency received a grant of $250,000 to enhance dental outreach efforts through the *Smile Alabama!* dental initiative. Funding for the grant was provided through the Robert Wood Johnson 21st Century Challenge Fund component of the Southern Rural Access Program and was matched by federal, state, and private funds to total more than $1 million.

The *Smile Alabama!* grant provided for a multifaceted campaign to recruit and retain a solid dental provider base for Medicaid children designed to improve access for Medicaid children to routine and preventive dental care through education, provider support, and fair reimbursement.

Summary

In summary, the *Smile Alabama!* Initiative was composed of four components:
1. Dental Reimbursement Increase
2. Claims Processing Simplification
3. Patient Outreach & Education
4. Provider Outreach

The Objectives of the Dental Outreach Initiative
- Provide adequate provider training and support, face-to-face
- Provide patient education on importance of prevention
- Provide training on the use of Targeted Case Management to address the no-show problems with Medicaid recipients
- Conduct provider recruitment visits
- Provide provider assistance with regularly scheduled follow-up calls
- Provide recipient education resources to providers
- Provide continued patient education resources/tools
- Assessment of success/failure to achieve program goals.

Claims Processing Changes
- Increase the consistency of the Medicaid claim submission format with that of other payers
- Provide adequate training and continued technical support for claims submission
- Maintain an effective and efficient claims processing system
- Provide timely responses to provider inquiries and claims resolution

Dental Reimbursement

- Increase rates to 100% of BCBS 2000 rates *(Implemented in October 2000)*
- Implement an annual rate review and necessary adjustments *(This has not occurred)*

Provider Outreach

- Encourage and support appropriate utilization of dental services
- Increase the number of patients accessing appropriate dental services
- Increase the number of providers who accept Medicaid patients
- Increase the number of providers who participate in early education of Medicaid-eligible dental patients

Recipient Outreach

- Increase the number of Medicaid recipients who make and keep appointments
- Increase the number of Medicaid recipients who know what to expect when visiting a dental office and what is expected of them (Rights & Duties)
- Increase the number of Medicaid recipients who are compliant with the usual policies and procedures followed in a dental office
- Increase the number of Medicaid recipients who practice basic preventive at-home dental care, with emphasis on the very young child

The grant monies also enabled the agency to produce a patient education video for statewide distribution. A contract to air radio and television public service announcements about the importance of oral health care began in October 2001. Easy-to-read patient education materials were developed and continue to be distributed through an online catalog available to Medicaid enrolled providers. Many of these materials can also be printed by consumers.

Outreach efforts have paid off in many ways. A growing number of providers began to file claims electronically, reducing the time required to process claims, and increasing provider satisfaction.

External outreach activities during 2002 included visits to Head Start programs and to school nurses. Health messages were incorporated into the *Alabama Guide for Families*, a statewide initiative to provide helpful information to new parents as well as for "passports" given to new parents through delivering hospitals. Other outreach activities included participation in health fairs, association meetings and an early learning project to encourage positive oral health behaviors and habits among pre-schoolers resulted in the development of curriculum materials for K-5 and Head Start classrooms.

Projects for 2003 included a second radio and television campaign and an outdoor advertising project to increase public awareness along with an early learning initiative to provide Head Start and other pre-school teachers with the lesson plans and materials needed to teach on key oral health topics. Two provider-oriented efforts were designed to encourage primary and maternity care providers to increase their emphasis on oral health as they provide anticipatory guidance to their patients.

While funded by the Robert Wood Johnson Foundation as a three-year grant, the Smile Alabama! Initiative has been sustained by the ongoing efforts of the Alabama Medicaid Dental Task Force, the Oral Health Coalition of Alabama and Alabama Oral Health Strategic Team (previously the AL NGA Policy Academy Team)

Additional strategies continue to be implemented based on input from this public-private partnership. An example of these continued efforts is the recent revamp and re-implementation of the 1st Look program, developed by the Agency in partnership with the state's pediatric dentists and pediatricians. The program is designed to reduce early childhood caries by encouraging primary care physicians to perform dental risk assessments, provide anticipatory guidance, apply fluoride varnish when indicated, and refer children to a dental home by age one.

The Alabama Medicaid Agency continues to work with other organizations participating in summits and ongoing efforts to improve the oral health status of Alabama's children.

Statistical Review

The initiative's goal of increasing the number of participating providers by 15 percent at the end of the three-year grant period was exceeded by the end of the first grant year. A goal of 18.6 percent was achieved at the end of the first grant year and 38.7 percent by end of year two. In addition, the number of counties with one or no Medicaid dental provider dropped from 19 to 11 in the first year of the initiative. As of September 2009, this number was down to three. The ability to increase participation in several counties is limited by the lack of dental providers in some rural areas. In order to increase Medicaid participating dentists in these areas workforce issues will need to be addressed to bring additional dentists to these areas. The Agency continues to work with our partners in this effort.

The second initiative goal was to increase the number of children receiving dental services (the Annual Dental Visit Rate) by at least 5% by the end of the three-year grant period. From FY 2000 to FY 2002, there was a 57.1% total increase with 50,000 more children receiving dental services, which equated to a 4.8% increase in the Annual Dental Visit Rate.

Alabama Medicaid Dental Program 1998-2007. Over the past ten years, Medicaid dental utilization rates in Alabama have improved from 25.2% in 1998 to 41.5% in 2007, a 62% increase (Figure 1). The number of enrolled providers during this time period has increased significantly, 55.3% (from 430 dentists to 778), and the number of providers treating at least one Medicaid child (performing providers) increased 48.1% (from 350 providers to 748). Most significantly, from 1998 to 2007 there has been a 216% increase (from 151 to 477) in the number of providers seeing more than 100 patients per year (Figure 2).

Figure 1. Alabama Dental Medicaid Utilization, 1998-2007

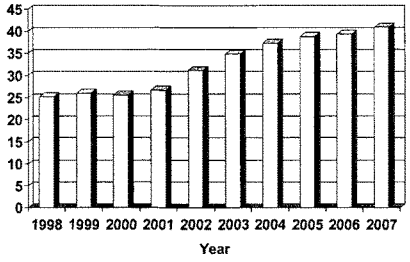
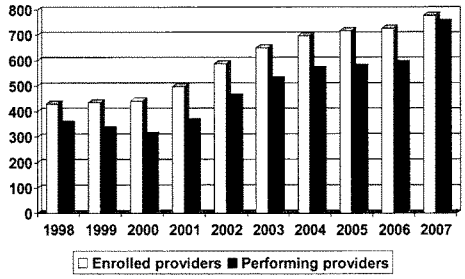


Figure 2. Enrolled and Performing Dentists, Alabama Dental Medicaid, 1998-2007



Impact of Smile Alabama!

Alabama Medicaid Dental Program FY 2001 to FY 2007. Since the implementation of the *Smile Alabama!* initiative in FY 2001, there has been an 84.3 percent increase in dental utilization, from 26.7 percent (103,630 children served in FY 2001) to 41.5% (190,968 served in FY 2007), while the number of Medicaid eligible children has risen sharply from 386,000 to 460,526 during this time period. Most importantly, county-specific data from FY 2001 to FY 2007 indicate that every county in Alabama has seen significant increases in utilization of dental Medicaid services, from a high of 177.7% increase in Baldwin county, to a low of 1.8% in Barbour county. Some nine counties recorded increases of over 100%, with Mobile and Montgomery counties included in this list. See **Attachment A** for current dental statistics.

Conclusion

In conclusion, in order to improve access to and the utilization of oral health care services a focus on prevention and early care is important. A multipronged approach much be taken for a complex, multi-faceted issue. Efforts must be ongoing and a variety of ways used to evaluate

program progress is critical to identifying progress (or the lack there of) and the reasons for this. The steps and strategies used have been numerous. None of us wants any child to suffer. I personally know what it is to be a child in severe pain from a dental abscess because my parents lacked the means to obtain care. States are struggling to maintain services in the light of severe budget shortfalls. States are using the resources they have (or can find) in order to increase the number of children receiving services.

We are currently experiencing increased enrollment due to the present state of the economy with shrinking budgets while trying to increase utilization. These factors will limit our ability to push utilization numbers up and must be considered in any discussions surrounding finding the solution to the dental access issue.

The importance of improving access to and the utilization of oral health care services have been communicated loud and clear to the Agency by CMS. It is important that everyone understand that improving the oral health status of this most vulnerable population will require an understanding of ALL of the factors that result in underutilization of dental services while also working to prevent this disease so that there is no need for a child to experience what Deamonte did.

Thank you for the opportunity to speak today on behalf of the Alabama Medicaid Agency and the recipients we serve.

FISCAL YEARS: 2003-2009

ES UNDER 21	Recipients who had Dental Services Under 21	Recipients who had Diagnostic Services (D0100-D0999) under 21	Recipients who had Preventive Services (D1000-D1999) Under 21	Recipients who had Treatment Services (D2000-D9999) Under 21	Recipients Under 6 with Extractions	Utilization %	% OF Diagnostic	% OF Preventive	% OF Treatment	Undup Performing Providers	Significant Providers who had > or = 50 recipients	Significant providers who had > or =100 recipients	Significant Providers who had > or = $10,000 in paid claims
,170	151,997	*N/A	131,660	85,144	4,446	34.85%	*N/A	86.62%	56.02%	524	358	287	369
,416	169,504	N/A	150,280	93,043	4,990	37.30%	N/A	88.66%	54.89%	566	417	328	414
,098	179,692	N/A	161,166	97,770	4,927	38.80%	N/A	89.69%	54.41%	572	412	347	422
,271	184,381	N/A	167,483	98,681	4,988	39.37%	N/A	90.84%	53.52%	587	429	375	375
,418	189,535	182,851	173,079	101,638	5,008	38.03%	96.47%	91.32%	53.62%	602	568	477	571
,058	203,595	197,409	188,016	106,447	5,183	40.63%	96.96%	92.35%	52.28%	595	486	406	487
,058	231,294	224,794	215,969	117,699	5,224	46.16%	97.19%	93.37%	50.89%	597	460	382	464
ision of s under 1 nning . **FY08 s utilized FY09.		*Columns were revised in November 2008 to reflect the procedure ranges in the CDT. Revisions go back to 2007.					*Columns were revised in November 2008 to reflect the procedure ranges in the CDT. Revisions go back to 2007.						

Mr. KUCINICH. Dr. Berg, you may proceed.

STATEMENT OF JOEL BERG

Dr. BERG. Good afternoon, Mr. Chairman and members of the subcommittee. I thank you for the invitation to testify today.

My name is Joel Berg, and I am the Chair of the Department of Pediatric Dentistry at the University of Washington, dental director at Seattle Children's Hospital, as well as the secretary-treasurer of the American Academy of Pediatric Dentistry. I am a practicing pediatric dentist, and I care for a large number of Medicaid eligible children. I am honored to appear before you today to represent and to share the success of Washington State's Access to Baby and Child Dentistry [ABCD] program.

The goal of ABCD is to expand access to oral health services by Medicaid eligible children from birth through their 6th birthday. More than a dozen nationally publicized articles and published articles have clearly demonstrated that early prevention reduces future dental costs and that ABCD is an effective, cost-saving method of improving the oral health status of children enrolled in Medicaid. The first ABCD program was established in 1995 in Spokane, Washington as a collaborative effort between public and private sectors. The community agreed that something needed to be done to address the severe lack of dental access among high-risk, low-income preschool children.

ABCD programs are locally administered by a health jurisdiction or a community agency that contracts with the local health department. The administrator then works with an identified ABCD dental champion, who is a leading pediatric dentist or general dentist who is selected and trained by the University of Washington to identify, recruit, train, and mentor other local general dentists. ABCD encourages general dental offices, not just pediatric general offices, to provide a positive dental experience and a dental home by age 1. The ABCD program is embedded in many local Head Start and Early Head Start programs, now both under the American Academy of Pediatric Dentistry Leadership.

In Washington State, ABCD is a collaborative effort of Washington Dental Service Foundation, the University of Washington School of Dentistry, the Department of Social and Health Services, the Washington State Dental Association, the Department of Health, local dental societies, and local health jurisdictions.

ABCD-certified dentists receive enhanced Medicaid reimbursement for selected procedures on enrolled children. Dental office staff receive training and communication in culturally appropriate followup with families, and the billing staff learns how to work with the Medicaid program.

With the growth of the ABCD program, an increasing number of Washington physicians is now addressing oral health during well child checks because ABCD-trained dentists serve as referral sites. Medicaid reimburses trained and certified primary care providers for delivering oral screenings, health education, employed varnish applications during well child checks, and they make the necessary referrals to dentists.

Today, 31 of Washington's 39 counties—more than 1,000 dentists—participate in ABCD, and several other States have ex-

pressed interest in adopting this successful program. ABCD has more than doubled the number of young Medicaid children in Washington to receiving dental care from 40,000 to 107,000—a utilization increase from 21 to 39 percent.

The ABCD program is reducing overall dental costs. Education/prevention is most cost-effective during the first 2 years of life, and ABCD is making progress toward increasing the number of children who receive care before their 2nd birthday. In 2008, nearly 22,000 children under age 2—19 percent of eligible children—received dental services. When the program began in 1997, only 3 percent, close to what is probably the national average today of eligible infants and toddlers, received dental care.

While targeted enhanced reimbursements for increased frequency of preventative interventions for young Medicaid children are extremely important, other elements must be present to ensure the success of ABCD. The Washington Dental Service Foundation coordinates the program at the State level, and provides 3-year startup grants to launch the program locally so that outreach to families, case management, support services for the dentists, and other critical activities are included.

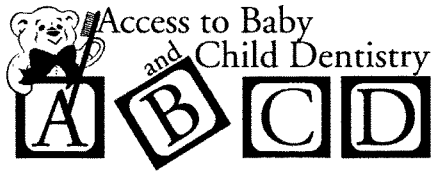
In the years ahead, the ABCD program will be expanding the use of risk assessment tools as exciting technologies are emerging. This combined with increasing incentives for earlier intervention and for higher risk children, an expanding partnership to refer the highest risk children—the highest risk and low-income children—to a dentist as early in life as possible will further improve the oral health of the program's children.

We must combat the growing crisis in childhood dental disease and increase access to care to some of our country's most vulnerable patients. ABCD is a proven best practice that is working in Washington State. I thank you for the opportunity to share the success, and we look forward to working with others States across the country to increase access to dental care.

Thank you.

Mr. KUCINICH. Thank you, Dr. Berg.

[The prepared statement of Dr. Berg follows:]



Statement

of
Access to Baby and Child Dentistry

Presented by
Dr. Joel Berg, DDS, MS
Lloyd and Kay Chapman Chair for Oral Health Chair
Department of Pediatric Dentistry
University of Washington

Domestic Policy Subcommittee
Oversight and Government Reform Committee

"Medicaid's Efforts to Reform since the Preventable Death of Deamonte Driver: a Progress Report"

Wednesday, October 7, 2009

2154 Rayburn HOB
2:00 p.m.

Good afternoon, Mr. Chairman and members of the Subcommittee.

Thank you for the invitation to testify today.

My name is Dr. Joel Berg, and I am the Lloyd and Kay Chapman Chair for Oral Health in the Department of Pediatric Dentistry at the University of Washington, Dental Director at Seattle Children's Hospital, as well as Secretary-Treasurer of the American Academy of Pediatric Dentistry. I am a practicing pediatric dentist and I care for a large number of Medicaid eligible children. I am honored to appear before you today to represent and to share the success of Washington State's "Access to Baby and Child Dentistry" Program, or "ABCD."

The goal of ABCD is to expand access to oral health services by Medicaid-eligible children ages birth through the 6th birthday. More than a dozen nationally published articles have clearly demonstrated that early prevention reduces future dental care costs, and that ABCD is an effective, cost-saving method of improving the oral health status of Medicaid-enrolled young children. The American Academy of Pediatric Dentistry and Association of State and Territorial Dental Directors have both named ABCD as a best practice, and the Program continues to receive awards and recognition from health organizations in Washington State and across the country.

Please allow me explain how ABCD was formed and how it works. The first ABCD Program was established in 1995 in Spokane, Washington as a collaborative effort between the public and private sectors. The community agreed that something needed to be done to address the severe lack of dental access among high-risk, low-income preschool children.

ABCD Programs are locally administered by a health jurisdiction or community agency that contracts with the local health department. The administrator then works with an identified ABCD "Dental Champion," who is a leading pediatric dentist (or a general dentist in areas without pediatric dental coverage) selected and trained by the University of Washington to identify, recruit, train and mentor other local general dentists. ABCD encourages general dental offices, not just pediatric dental practices, to provide a positive dental experience and a dental home by age 1. The local dental society, participating ABCD dentists, the health department, and outreach agencies work together to identify and refer eligible clients. The ABCD Program is embedded in many local Head Start; Early Head Start, now both under AAPD leadership; and Women, Infant and Children (WIC) Nutrition programs, which enroll and orient their clients, and at the same time, help achieve the agencies' client oral health objectives.

In Washington State, ABCD is a collaborative effort of Washington Dental Service Foundation, the University of Washington School of Dentistry, the Department of Social and Health Services, the Washington State Dental Association, the Department of Health, local dental societies, and local health jurisdictions.

ABCD certified dentists receive enhanced Medicaid reimbursement for selected procedures for enrolled children. Dental front office staff receives training in communication and culturally appropriate follow-up with the client families, and the billing staff learns how to work with the Medicaid program. By scheduling patients appropriately and effectively using the auxiliary staff to assist families with oral health education components of the visits, the ABCD Program is productive and cost-effective.

With the growth of the ABCD Program, an increasing number of Washington physicians are now addressing oral health during well-child checks because ABCD-trained dentists serve as referral sites. Medicaid reimburses trained and certified primary care providers for delivering oral screenings, health education and fluoride varnish during well-child checks and referral to a dentist as needed.

Today, 31 of Washington's 39 counties – more than 1,000 dentists – participate in ABCD, and several other states have expressed interest in adopting this successful Program. ABCD has more than doubled the number of young Medicaid children in Washington who are receiving dental care – from 40,000 to 107,000, a utilization increase from 21% to 39% in the last 10 years. In addition, these ABCD patients have improved health, as they are more likely to seek care before oral health problems arise.

The ABCD Program is reducing overall dental costs. Prevention is most cost-effective in infants during their first two years, and ABCD is making progress toward increasing the number of children who receive care before their second birthday: in 2008, nearly 22,000 children under age two, 18.7% of eligible children received dental services. When the Program was initiated in 1997, only 3% of eligible infants and toddlers received dental care.

While targeted enhanced reimbursements, for increased frequency of preventive intervention visits for young Medicaid children are extremely important, other elements must be present to ensure the success of ABCD. The Washington Dental Service Foundation coordinates the program at the state level and provides three year start-up grants to launch the program locally so that outreach to families, case management, support services for the dentists and other critical activities are included..

In the years ahead, the ABCD Program will be growing the use of risk assessment tools, as exciting technologies toward that end are emerging, increasing incentives for earlier intervention, and expanding partnerships to refer the highest risk, low-income children to a dentist as early in a child's life as possible.

We must combat the growing crisis of childhood dental disease and increase access to care for some of our country's most vulnerable patients. ABCD is a proven best practice that is working in Washington State. Thank you again for the opportunity to share this success, and we look forward to working with other states across the country to increase access to dental care.

Mr. KUCINICH. Dr. Catalanotto, you may proceed.

STATEMENT OF FRANK CATALANOTTO

Dr. CATALANOTTO. Thank you.

Good afternoon, Mr. Chairman and Ranking Member Jordan and members of the committee.

My name is Dr. Frank Catalanotto. I am Chair of the Department of Community Dentistry and Behavioral Science at the University of Florida College of Dentistry. I am here today on behalf of the American Dental Education Association [ADEA].

ADEA's membership consists of academic dental institutions who serve as dental homes for a broad array of racially and ethnically diverse patients, many of whom are uninsured, underinsured or reliant on public programs such as Medicaid and the Children's Dental Health Program.

The American Dental Education Association is grateful for the opportunity to share our perspectives and recommendations for improving the children's dental program and Medicaid.

First, a couple of comments about academic dental institutions as safety net providers, and this is the answer to some of your questions, Mr. Jordan.

Academic dental institutions include dental schools and dental hygiene schools that provide dental care reduced fees and provide millions of dollars of uncompensated care in our clinics each year.

All 59 U.S. dental schools and over 200 schools of dental hygiene operate clinics that teach students how to treat a broad array of patients and conditions as part of our educational mission.

On average, over 53,000 patient visits were conducted annually at each U.S. dental school, totaling more than 3 million patient visits; and over 50 percent of those patients were on public assistance programs. At the University of Florida college clinics, we had over 101,000 patient visits in 2008; and 76 percent of those patients were at 200 percent of the poverty level or below.

A couple of comments about Medicaid dental benefits and academic dental institutions.

Safety net dental programs and community health centers, local departments and academic dental clinics operating at full capacity are only able to meet about 8 percent of all the unmet dental needs in this country. There are few public subsidies that are available to academic dental institutions to help pay for the uncompensated care we provide.

Medicaid dental reimbursement levels have also been historically low. On average, they equal the lowest 10 percent of market rates in many States. In Florida, for example, our Medicaid reimbursement fees rank at 49th of the States. Therefore, 74 percent of the 18,000 children we saw in the University of Florida college and university clinics were at or below poverty level. In other words, they were on Medicaid. And the low reimbursement rates we receive put considerable strain on our ability to continue providing these services.

I would like to give you two examples of how academic dental institutions can help improve access to care in the United States.

The University of Florida College of Dentistry has a Statewide network for community oral health that operates five dental clinics

and is affiliated with nine other clinics throughout the State of Florida, from Miami to the border of the western part of the State; and these partners include federally qualified community health centers, county health departments, and a mobile dental van. The network serves Florida's most vulnerable populations and provides comprehensive dental care in the areas of greatest need around the State.

The second example, in 2002, the Robin Wood Johnson Foundation and the California endowment funded a program to promote community based dental education in 23 dental schools with grants totaling approximately $38 million. One of the dental schools funded was the Ohio State University College of Dentistry. The College's goal with the Robin Wood Johnson money was to reach populations in need of dental care across the State. Starting in 2003, when they first received the grant, the dental school had 10 community based sites. By 2007, they had expanded to 46 sites where their dental students and residents provide dental care to underserved and low-income minority income patients.

So what are the recommendations we have? My written testimony provides eight specific recommendations that ADEA would suggest, but I would like to focus on just three of them.

First, fund the expansion of community based dental education learning programs with academic dental institutions, and the Robin Wood Johnson pipeline project is an example of the kind of funding that maybe could be provided at both the Federal and at the State level.

Second, develop standards and protocols for models of care that allow other primary care professionals to help gather data, detect clinically pathological conditions, dental conditions, triage, and refer patients to appropriate dental professionals for care.

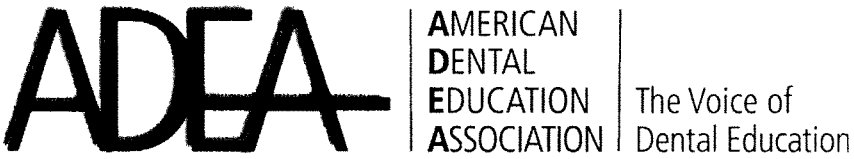
One of the questions asked earlier was about the role of physicians in providing oral health services. You may have noticed in my background that I have a grant from HRSA to actually train physicians to provide such care to provide oral health preventive services that are funded by Medicaid, and involving other members of the health care team is a critical step in this process of addressing access to care.

No. 3, provide Federal funds to States for school-based oral health promotion, education, and prevention programs. School-based sealant programs are another example. In other words, bring care to the K–12 school system where the children are.

In conclusion, the American Dental Education Association believes it is critical for Congress to preserve basic medical services for Medicaid beneficiaries and safeguard essential Medicaid dental benefits in any reform of the U.S. health care system. ADEA and its member institutions are prepared to work with Congress and other health care advocates to identify programs and policies that will increase access to care for underserved patients in Medicaid.

That is my testimony. Thank you very much.

[The prepared statement of Dr. Catalanotto follows:]



Statement of the
American Dental Education Association (ADEA)

Presented by
Frank A. Catalanotto, D.M.D.
Chair
Department of Community Dentistry and Behavioral Science
at the University of Florida College of Dentistry

Domestic Policy Subcommittee
Oversight and Government Reform Committee

Wednesday, October 7, 2009
2154 Rayburn HOB
2:00 p.m.

My name is Frank Catalanotto. I am a Professor and Chair of the Department of Community Dentistry and Behavioral Science at the University of Florida College of Dentistry. I am here today on behalf of the American Dental Education Association (ADEA)[i]. ADEA's membership of academic dental institutions serve as dental homes for a broad array of racially and ethnically diverse patients many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their health care.

The American Dental Education Association is grateful for this opportunity to share our perspective and recommendations for improving children's dental programs in Medicaid. We believe that a strong dental program within Medicaid is essential to reducing preventable and costly emergency dental care. ADEA and its members are doing all they can with shrinking budgets and limited resources to improve access to dental care for low income and disadvantaged children. We are ready to work with the members of this Committee and with Congress to address both the access and fiscal problems affecting children's access to dental care in Medicaid.

In my testimony, I will provide you with an overview of the context in which children's dental disease exists in our nation, with some specific ways in which ADEA's members are striving to address access problems and finally offer recommendations regarding some actions that Congress can take to improve children's access to dental care.

Dental Disease Burden and Children's Oral Health Disparities

The Surgeon General's report declared dental caries (tooth decay) to be one of America's most widespread infectious diseases, five times more common than asthma and seven times more common than hay fever in school children. Cleft lip/palate is one of the most common birth defects.

The burden of dental disease, in terms of both extent and severity, has shifted dramatically to a subset of our children. About a quarter of the population now accounts for about 80 percent of the disease burden. Native American, Alaska Native, Hispanic and African-American children are far more likely to have untreated dental caries than Caucasian children.[ii] Dental caries also remains a significant problem for children with special care needs.

Examples of Children's Oral Health Disparities

- The rate of tooth decay for Hispanic toddlers is 4.5 times that of Caucasian children.
- The rate of tooth decay among American Indian and Alaska Native children is 3 to 4 times that of the rest of the population.
- African American children are 40% less likely to have preventive dental sealants.
- African American children are more likely to have their teeth extracted than white children.
- Almost twice as many Hispanic children (40%) as Caucasian children have untreated tooth decay.
- Rates of untreated tooth decay for American Indian and Alaska Native children are 3 times higher than the rest of the population.

- Children and adolescents with special health care needs are 2 times as likely to have unmet oral health care needs across all income levels.
- Parents of children with disabilities consistently report dental care as one of the top needed services regardless of age.

Children's Access to Dental Care

Nine million children lack health insurance coverage but three times as many (20 million) have no coverage for dental services. Even those with coverage may experience problems accessing dental services as many still do not have access to dental services because of a lack of dental providers in their communities. Over 4,000 counties or partial counties have been designated dental Health Professions Shortage Areas (D-HPSA) where individuals suffer from an absolute lack of dental providers. Less than half of these communities are served by safety-net providers.

Unlike medicine (in which 75 percent of physicians accept patients on public programs such as Medicaid and the Children's Health Insurance Program) only about 25 percent of practicing dentists see patients enrolled in public programs. In Florida, only 10 percent of dentists participate in the state's woefully underfunded Medicaid program. States often have difficulty enrolling participating dentists in public programs such as Medicaid and SCHIP because reimbursement rates are one-half to one-third of fees in private dental practice.[iii] Dentists are also resistant to the burdensome administration of the public system which often varies greatly from private dental insurance.[iv] Consequently, millions of children enrolled in publicly insured programs that are entitled to dental services experience difficulties receiving care.

These factors were at play in the case of 12-year-old Deamonte Driver whose mother could not find a dentist to treat her son before his tooth infection spread to his brain and tragically resulted in his death. His death could have been avoided by simply removing his tooth, a procedure costing about $80. Though covered by Medicaid, neither the boy's family or legal aid attorney were able to find a dentist willing to take new Medicaid patients. The consequences of not having access to oral health care can be severe and fatal.

Access problems will grow too, as large numbers of dentists retire during the next 10 to 15 years. The looming retirement of aging dentists is expected to occur at a 2 to 1 ratio to the number of new dentists graduating over the next decade.[v] Growth among minorities is increasing the need to recruit and train a more diverse dental workforce. By the year 2050, nearly one in five Americans (19 percent) will be an immigrant, compared with one in eight (12 percent) in 2005. Despite these population trends, minorities are underrepresented in the U.S. health care workforce. This is no less true of dentistry, where they comprise less than five percent of dentists and about nine percent of dental faculty.

Demographic Trends

- Minorities will grow from 1/3 of the U.S. Population to over ½ (54%) by 2050.
- In 2050, 235.7 million U.S. residents will be minorities.
- The largest growth will be in the number of Hispanic/Latinos doubling to 30 percent (132.8 million).
- By 2030, minorities will comprise more than one-half of all children.

An Inadequate Dental Safety-net

The nation's dental safety-net is a loosely organized spattering of clinics and providers that have limited access to health information technologies, electronic health records and other tools to operate at optimum capacity. Safety-net dental programs in community health centers, local health departments, and academic dental clinics at full capacity are able to meet only about eight percent of all unmet dental needs.

Many safety-net dental clinics also experience significant gaps in their capacity to provide comprehensive dental services. As a result, academic dental clinics, particularly those situated on campuses, are often a major source for a full range of specialty dental services and often the most complex cases are treated there. Unlike other safety-net providers, such as hospitals and community health clinics, there are few public subsidies available to academic dental institutions to help pay for the uncompensated dental care they provide.

Impact of the Economy on Medicaid Dental Benefits

The economic downturn has affected almost every state budget. Forty-eight states reported budget shortfalls for fiscal year 2010[vi]. Medicaid continues to challenge budgets as enrollment increases with the loss of jobs in states and more individuals are forced to seek Medicaid coverage with the loss of their employer-sponsored health insurance coverage. Medicaid accounts for more than 20 percent of total state spending and continues to outpace state spending on all other programs except for K-12 education.

Medicaid dental programs are already woefully underfinanced, accounting for only about 1.5 percent of all Medicaid expenditures ($5 billion of the $329.4 billion spent on Medicaid in 2007). Medicaid dental reimbursement levels have also been historically low; on average, they equal the lowest 10 percent of market rates in many states.[vii] Sadly, states continue to look to cut Medicaid dental benefits in difficult economic times.

Since 2008 fifteen states have made dental cuts. Some of these cuts have affected children's dental benefits by lowering annual caps on payments for dental services, restricting or eliminating certain procedures (including dental surgery), and cutting fees to providers which have even forced safety-net dental clinics to close their doors. Medicaid program cuts continue to impact low-income children's access to dental care. Without sufficient access to dental care in Medicaid, millions of low-income families opt to postpone needed dental care until a dental emergency occurs requiring immediate, more complicated and more expensive treatment.

Medicaid: Still an Important Dental Safety-Net

Despite the problems associated with financing and access to dental care, Medicaid is still a major source of care for approximately one-quarter of all children and half of the nation's poor children. All 29 million children in Medicaid are eligible for needed dental care through the Early Periodic Screening, Diagnosis and Treatment program (EPSDT). In 2006, 73 percent of children aged 2-17 with public coverage had a dental visit during 2005, compared with only 48 percent of uninsured children. [viii]

Programs like EPSDT that provide early preventive dental treatment for children result in costs that are 40 percent lower[ix] than when their oral health is neglected. For example, in Florida from July 2006 through June 2007, 196 Medicaid recipients under age six were admitted to hospitals for an average of 3.7 days for life-threatening dental infections[x] Early prevention for these patients could have saved the Medicaid system more than one million dollars—not counting parents' lost time at work.[xi] According to another report by the California Dental Health Care Foundation, the number of emergency department visits for preventable dental conditions is growing at a faster rate than the state's population. The rate of preventable dental admissions is twice that for diabetes and asthma.

The Role of Academic Dental Institutions in Improving Access

U.S. academic dental institutions (ADIs) are the fundamental underpinning of the nation's oral health. ADIs play an essential role as major contributors to the dental safety net, in conducting research and unveiling scientific evidence that leads to improvements in oral health, and in educating and training the future oral health workforce. Academic dental clinics serve as key referral resources for specialty dental services not generally accessible to Medicaid and SCHIP patients. ADIs provide care at reduced fees and provide millions of dollars of uncompensated care in their clinics each year. States look to ADIs for assistance in administering and supporting a variety of community dental programs including school-based sealant programs and assessments of dental workforce needs.

All 59 U.S. dental schools operate clinics that teach students how to treat a broad array of patients and conditions as part of their educational mission. All dental residency training programs provide care to patients through dental school clinics or hospital-based clinics and all dental hygiene education programs operate on-campus dental clinics where classic preventive oral health care is provided four to five days per week in compliance with state practice acts.

Snapshot of Patient Care Provided Through Dental Schools

- On average 53,298 patient visits were conducted annually per U.S. dental school through on-campus and extramural facilities (2005-06).
- On average 6,106 dental screenings were provided annually per U.S. dental school (2005-06).
- 81% of all U.S. dental schools in 2005-06 offered clinical training opportunities at off-campus locations.

A report by the American Dental Association on dental school community-based clinics found that public assistance programs, such as Medicaid and Medicare, cover about 50 percent of patients seen at academic dental clinics. Almost one-third of patients (32 percent) had no dental insurance coverage. Over 65 percent were members of families with annual incomes of less than $15,000 (1998) and 41 percent of patients were under the age of 14.

Community-Based Service Learning

Community-based rotations have been successful in increasing access to dental care by placing dental students and faculty in settings that reach underserved communities. Community-based clinical experience refers to students who provide patient care in community-based clinics or private practices. Over 92 percent of all dental curricula require community-based clinical experiences.[xii] Creating partnerships between academic dental institutions and community-based programs helps increase the number of clinics able to address the underserved community's oral health needs. Community clinics are usually more convenient for patients who do not have to travel long distances for their care.

Surveys have shown that students who complete rotations in underserved communities during their dental education tend to include these populations in their patient mix after they graduate and become practicing dentists.[xiii] During community rotations, students get a lot of experience working with a diverse patient mix, including pediatric, minority, geriatric, and special needs patients. Through exposure to this diverse patient mix, dental students expand their clinical training experiences, increase their cultural competency, and gain an understanding of their social responsibility as health care professionals. They understand the extent of the need for care among those who are underserved because they have seen it first-hand. When dental students graduate they feel competent to address the oral health needs of underserved populations in their communities.

Community-based dental education is an effective method of educating dental students.[xiv] Students enjoy community rotations for the opportunities they provide to learn in an integrated care setting and to familiarize themselves and become comfortable treating a diverse patient population. Below are some examples of academic dental institutions efforts to increase access and enhance student care experiences through community-based dental education programs.

1) The Robert Wood Johnson Foundation and The California Endowment funded the *Pipeline, Profession & Practice: Community-Based Dental Education program* (Dental Pipeline). This program, which began in 2002, has four main goals: 1) to increase services provided to vulnerable populations through dental school community-based collaborations; 2) to train graduates with the cultural knowledge and communication skills they need to treat racially and ethically diverse patients; 3) to increase student body diversity; and 4) to graduate more dentists who choose to practice in communities-of-need. The first round of grants were distributed in 2002, and the second round in 2008. In order for dental schools to be eligible for funding, they had to establish community-based clinical education programs; revise their curriculum to incorporate community-based practice experience into their educational programs; and implement programs to increase recruitment and retention of underrepresented minority and low-income students. The results with regard to community-based education have been very positive.

A Snapshot of Dental Pipeline

- 344 facilities participated in the RWJ/TCE Pipeline program
- 63 percent of facilities were in rural areas
- FQHCs participating in program grew from 28 (14 percent) to 76 (22 percent)
- dental students provided 128,936 services in underserved communities
- 68,636 patients (55 percent were African American, Hispanic or Native American)
- 25,937 patients were seen as part of these extramural rotations in Federally Qualified Health Centers (FQHCs)

Program Participants

2002-2007	2008-2010
Boston University	A.T. Still University of Health Sciences
University of Connecticut Health Center	Creighton University
Howard University	Texas, A&M Health Science Center
West Virginia University	Medical College of Georgia Research Institute, Inc.
University of North Carolina at Chapel Hill	The University of Maryland Baltimore
Meharry Medical College	University of Florida
University of Illinois at Chicago	University of Medicine and Dentistry of New Jersey
The Ohio State University	Virginia Commowealth University
University of Washington	
University of California at San Francisco	
Temple University	
University of California at Los Angeles	
University of the Pacific	
University of Southern California	
Loma Linda University	

2) The University of Florida College of Dentistry (UFCD) Statewide Network for Community Oral Health. This program began in 1997 to increase access to oral health services for underserved populations in Florida and provide more learning environments for students and residents. UFCD began the program through partnerships across the state. UFCD now owns five dental clinics and is affiliated with another nine clinics, including federally qualified community health centers, county health departments and a mobile dental van. Students and residents offer services in these clinics and complete rotations throughout the state in a variety of settings affiliated with the Department of Health, community health centers, or private or non-profit entities. The Network provides comprehensive dental care, emergency services, hospital-based treatment, and preventive dental services and education for children and adults throughout Florida. It serves Florida's most vulnerable populations and provides care in areas of great need.

UFCD Statewide Network for Community Oral Health (2008)

101,686 patient visits
25,552 children's visits
76,134 adults
80,835 of patients seen (76%) live at or below 200% of federal poverty
18,742 of children seen (74%) were at or below the poverty level

Upon review of Medicaid statistics in Florida, it is clear that although Medicaid is the program serving low-income and vulnerable populations, there are issues to be

addressed to ensure their access to care. Only about 26 percent of Medicaid recipients receive dental services. Only 10 percent of children under age six receive any dental services. The ratio of Medicaid dentists to eligible children in Florida is 1:7,610. Until these Medicaid numbers change, UFCD Statewide Network of clinics, students, and residents will remain a primary source of dental care for the poor and underserved in Florida.

3) **Ohio State University's Oral Health Improvement through Outreach [OHIO] Project**. This Ohio State University (OSU) College of Dentistry (COD) program is part of the dental pipeline. It focuses on recruitment of underrepresented minority students, curricular changes, and extramural clinical rotations. When the College of Dentistry submitted the proposal to the Robert Wood Johnson Foundation, the state had already identified oral health as its top unmet health care need. Access to dental care is a significant problem in Ohio especially for urban poor and minority populations including African Americans, immigrant Asians, Hispanics, Somalis, disabled children and adults, and the rural Appalachian poor. While 11 percent of Ohioans are uninsured for health care, 41 percent (4.6 million people) do not have coverage for dental care.[xiv] The College of Dentistry's goal in the Pipeline program was to reach populations in need of dental care. Starting from four rural and six urban sites in 2003, the OHIO Project has expanded to include seventeen rural and twenty-nine urban sites in 2007. In 2003, thirteen students were sent on rotations for a total of five days; by 2007, the entire fourth-year class was going on rotations and spent nearly sixty days in community rotations.

The Role of the Federal Government: Recommendations for Improving Children's Access to Dental Care

Academic dental institutions have a reciprocal relationship with Medicaid in accessing funding for, and providing services through, dental education programs that treat underserved populations, including those on Medicaid. The strong role that ADEA member institutions serve as major dental safety-net providers, combined with the broad range of oral health policy expertise and interests we represent, qualify ADEA to offer the following recommendations to improve access to dental care for children enrolled in Medicaid.

1) **Preserve eligibility for the full scope of dental services available under the EPSDT program for children in Medicaid.** Any plan that would substitute the eligibility or benefit standards under EPSDT will weaken critical dental services for millions of children. Alternatives to EPSDT would not reduce states' health care costs. Rather, they would significantly drive up costs by replacing cost-effective preventive care provided by EPSDT with more costly emergency treatment.

2) **Fund the Expansion of Community-Based Service Learning Programs Within Academic Dental Institutions.** Provide funding for programs that increase access to oral health care through collaborative partnerships between state Medicaid programs, community health centers and academic dental institutions. Academic dental institutions have been innovative laboratories for community-service learning programs that increase access to dental care for low-income and vulnerable populations. Academic dental institutions offer several advantages that fill gaps in state Medicaid oral health programs, including: 1) access to research on oral disease and prevention; 2) model programs in educating the public regarding good oral health; and 3) experience in

providing oral health services to Medicaid populations including those with special needs.

3) Provide a Federal "dental disproportionate share" (DDS) payment to academic dental institutions (ADI) and other dental safety-net providers that serve large numbers of underserved children who are at a higher risk for acute dental disease. Academic dental clinics are well-equipped to meet the needs of large numbers of underserved children whose dental care has been neglected and whose conditions as a result are often complex. DDS payments will ease the costly burden facing ADIs when Medicaid or SCHIP reimbursement rates are artificially low and when they are not reimbursed at all for services to uninsured children.

4) **Provide Federal funds to states for school-based oral health promotion, education and prevention programs**. Provide Federal funding to States and Indian Tribes for the development and implementation of school-based oral health promotion and disease prevention programs. Eligible schools must be located within an area that is designated as dentally underserved or in rural or urban settings when 50 percent of students are eligible for Medicaid or SCHIP. Funds would be used to enable schools to provide children with basic education, prevention and emergency dental care by licensed dental professionals within their scope of practice.

5) **Increase funding and support for Federal Programs that are critical to building the primary care dental workforce such as the Title VII General and Pediatric Dentistry Programs**. Support for these programs is essential to expanding existing or establishing new general dentistry and pediatric dentistry residency programs, which have shown to be effective in increasing access to dental care for vulnerable populations, including patients with developmental disabilities, children, and geriatric patients. These primary care dental residency programs generally include outpatient and inpatient care and afford residents an excellent opportunity to learn and practice all phases of dentistry, including trauma and emergency care, and comprehensive ambulatory dental care for adults and children.

6) **Develop standards and protocols for models of care that allow primary care professionals to gather data, detect clinically apparent pathologic conditions, triage and refer patients to appropriate dental professionals for care**. States should be encouraged to adopt models of care that develop stronger linkages between pediatricians, family physicians, geriatricians and other primary care providers as team members with dentists in assessing and identifying dental disease. Dental schools and oral health professionals could serve as oral health team leaders providing the necessary guidelines for education and training that would enable all primary health care professionals to assess the oral health status of their patients and make appropriate referrals to dentists and other allied dental professionals.

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

8) **Oral Health Benefits in Health Care Reform.** The House Tri-Committee (HR 3200) and the Senate HELP health care reform bills include provisions that require oral health services for children. The Senate bill establishes an "Affordable Health Benefit Gateway" through which individuals and specified businesses can purchase insurance. All plans that participate in the program *must include oral health benefits for children.* Likewise, the House reform proposal establishes a "Health Insurance Exchange" program through which individuals and specified businesses can buy insurance. All plans that participate in the program *must include oral health benefits for children.* The American Dental Education Association (ADEA) strongly supports these provisions. Including access to oral health care for children is vital to ensuring that children grow up strong and healthy.

However, adults also need access to and coverage of oral health care services as a basic benefit. (The House Tri-Committee legislation would allow only for an optional adult oral health benefit at an additional cost in its "premium-plus" benefit package.) As health care reform legislation is aimed at helping those most in need, dental care cannot be forgotten. ADEA is committed to the proposition that every American should have access to and coverage of affordable diagnostic, preventive, restorative, and primary oral health care services so as to eliminate pain, suffering, and infection.

Conclusion

Academic dental institutions have a human and financial stake in preserving the basic foundation and funding of the Medicaid program and in ensuring that the nation's youngest, poorest and sickest citizens have access to basic and preventive oral health services. ADEA believes it is critical for Congress to preserve basic services for Medicaid beneficiaries and safeguard essential Medicaid dental benefits in any reform of the U.S. Health Care system.

ADEA and its member institutions are prepared to work with Congress and other oral health advocates to identify programs and policies that will increase access to dental care for underserved children in Medicaid through cost-effective and affordable means.

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[i] The American Dental Education Association represents all 59 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided. ADEA member institutions serve as dental homes for a broad array of racially and ethnically diverse patients, many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their health care.

[ii] U.S. Department of Health and Human Services. *The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001*, Health Resources and Services Administration, National Center for Workforce Analysis Bureau of Health Professions, Washington, D.C., April 2004

[iii] Moskowitz, M.C., *State Actions and the Health Workforce Crisis*, Association of Academic Health Centers, Washington, D.C., 2007.

[iv] American Dental Association, *Increasing Access to Medicaid Dental Services for Children Through Collaborative Partnerships*, Washington, D.C., March 2004.

[v] Beazoglou T., Baillit H., Jackson-Brown L, *Selling Your Practice at Retirement: Are There Problems Ahead?,* Journal of the American Dental Association, December 2000, 131(12):1693-1698.

[vi] Center for Budget and Policy Priorities, Lay, IJ, McNichol, E. "New Fiscal Year Brings No Relief From Unprecedented State Budget Problems," September 3, 2009.

[vii] Crall, J. and Schneider, D., with American Dental Association (Ed.). *Medicaid reimbursement: Using marketplace principles to increase access to dental services.* 2004.

[viii] Paradise J, Dental Coverage and Care for Low-Income Children: The role of Medicaid and SCHIP, The Kaiser Commission on Medicaid and the Uninsured, July 2008.

[ix] Sinclair, S., Edelstein B. *Cost effectiveness of Preventive Dental Services.* Washington, DC. Children's Dental Health Project, February 2005.

[x] Shenkman, E.A., Chair, Department of Epidemiology and Health Policy, University of Florida (presented by Frank Catalanotto to the Florida legislature, July 2008.)

[xi] Lee et al. *Examining the cost-effectiveness of early dental visits.* Pediatric Dentistry 2006; 28(2):102-105, 192-198.

[xii] American Dental Association, Survey Curriculum – 2006-2007.

[xiii] Baumeister SE, Davidson PL, Carreon DC, Nakazono TT, Gutierrez JJ, Andersen RM. What influences dental students to serve special care patients? Spec Care Dent 2007;27(1):15–22.

[xiv] DeCastro JE, Bolger D, Feldman CA. Clinical competence of graduates of community-based and traditional curricula. J Dent Educ 2005;69(12):1324-31.

[xiv] ADEA *Journal of Dental Education. Volume 73, Number 2 Supplement* February 2009

Mr. KUCINICH. Thank you, Doctor.

Now you gave us three out of eight.

Dr. CATALANOTTO. There were two, sir—my apologies—two of the ones I wanted to assess. My error.

Mr. KUCINICH. I just wanted to make sure that you feel that you communicated your major points.

Dr. CATALANOTTO. The other six are provided in detail in the written testimony.

Mr. KUCINICH. OK. I just want to make sure that you had a chance to note that. It sounded like you were on a roll there. I didn't want to cut you off.

Dr. CATALANOTTO. Thank you.

Mr. KUCINICH. Let's go to questions for the witnesses.

Dr. Edelstein, in your prepared testimony, you address the situation that occurred in Georgia where vendors cut providers from their networks to ward off utilization increases imposed by the States. This is clearly an unintended consequence of reform that was intended to increase access to care.

In your opinion, what does the evidence suggest about the consequences of relying upon Medicaid managed care organizations to provide dental coverage to children?

Dr. EDELSTEIN. What I am referencing there is specifically placing managed care companies at financial risk. And, as was mentioned earlier, depending upon the quality of the contracts and the degree of oversight, it is possible to have a variety of relationships between a State and a managed care company and still have a satisfactory outcome.

However, in the case of dentistry per se, there is very little that managed care companies concurrently do to manage the care in order to effectuate savings; and so the primary technique that they have left to rely upon in order to protect their profit line—because these are for-profit at-risk companies—is to control utilization. And that means that there's a perverse incentive built into the concept with regard to dentistry, because there's very little else that the managed care company can do to protect its bottom line.

Mr. KUCINICH. Thank you, Doctor.

Drs. Berg and McIntyre, if you could both give a try at answering this one.

Patient compliance is often cited as a barrier to improving outcomes in State Medicaid dental programs. Both of your programs have a case management component. And what are some of the specific interventions of case management?

Before you answer that question—Ms. Mann, I just want to note something. First of all, you may be one of the only administration official who has actually stayed to hear witnesses on the next panel. It's very rare and refreshing. Thank you.

So, Dr. McIntyre and Dr. Berg, what are some of the specific interventions of case managers in your programs that increased patient compliance?

Dr. MCINTYRE. I want to start first with a regional—because we kind of redesigned things with our First Look Program, but we originally wanted to address the issues that the providers themselves talked about, which was the missed appointment. And what the care coordinators provided was the means of actually contact-

ing patients to assist them with getting into their providers' offices. You know, they address issues such as the care of the other children, which is something that a lot of times people didn't think about. Well, what did they do with the other kids when they really have an appointment to see the dentist for maybe one or two of those children, issues such as transportation to the dental office.

And sometimes there were issues that didn't have anything to do with the transportation. There were issues concerning, well, I don't know how I am going to pay rent tomorrow, so I am not really worried about keeping a dental appointment next week. So that the care coordinators had to get into not just the issues of the dental appointment themselves but also the other issues that were surrounding the reasons why these patients wouldn't keep appointments.

And then one of the things we had to deal with was also to address the dental provider's problem about behavior in the office, and we did that also as part of this program. We are trying to educate them on, you know, taking one child and making sure that you are on time for your appointments.

Mr. KUCINICH. Thank you, Dr. McIntyre.

Dr. Berg, would you like to respond?

Dr. BERG. Yes, Mr. Chairman.

I think you were pointing out that one of the most important aspects of the ABCD is the local ABCD coordinator. It is a county specific—or local health jurisdiction specific program. And we found, indeed, that in the smaller local health jurisdictions it's easier to get access to care through the ABCD program because it's easier in the smaller communities to coordinate efforts. We found, actually, that we had lower no-show rates than some of the ABCD programs in most jurisdictions then with the non-Medicaid populations. We have evidence to show that.

So these care coordinators are absolutely critical in the scheme of things to make things work. We have evidence of that in different counties.

Mr. KUCINICH. Thank you, Dr. Berg.

The GAO study reveals that States overwhelmingly would like additional guidance from CMS. So if we could again hear from Drs. McIntyre and Berg, from the State perspective, what specific suggestions do you have for CMS to improve the guidance they provide to State Medicaid systems?

Dr. MCINTYRE. Well, as a State that I think we had a relatively—what could I say—a very good relationship with our regional office when it came down to getting assistance, we didn't have any problems recalling. But specifically when it comes down to recommendations, the main thing is to communicate specifically what we can and cannot do from a State standpoint. And I think a lot of times States are under the, I guess, misinformation as far as with misunderstandings about what policies will allow them to do or not do.

But we didn't have it, that particular issue, because we got clear communication about, well, you know, when it came down to Smile Alabama!, no one told us that we couldn't go after outside funding, so we did. We did a check, and it was OK. So we went after funding in order to do the program.

But I think there's something that other States need to know, that you don't have to deal with just the money that you have, you know, within the State coffers, that you can look beyond that and identify private-public partnerships in order to do some of the programs that you want to do from a State standpoint.

Mr. KUCINICH. Thank you, Doctor.

Dr. Berg, if you could answer. My time has expired, but please just give a brief answer.

Dr. BERG. Yes, please. I will give specific recommendations.

The State of Montana just adopted an ABCD-like program modeled after Washington State's program. They actually did what we would have liked to have done this year, but it wasn't fundable in the current legislature, and that is to incentivize earlier intervention where we can separate the highest-risk children.

We know that, as was stated earlier, 80 percent or something of the cost is spent on 25 percent of the children, and that starts at about age 2½ or 3. If at age 1 we can identify who they were and segregate them and have more aggressive intervention for the higher-risk children, we can save money. We have actually done an economic modeling of this through our health economist and have shown that it can work.

So I would absolutely look right now at earlier intervention, incentivizing earlier intervention, incentivizing higher risk, more aggressive interventions.

Mr. KUCINICH. Thank you very much.

The Chair recognizes Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman.

Let me thank the witnesses, too, and for your commitment for helping these children.

You know, the goal is, as Dr. Berg just said, to treat them as early as possible so we save on costs in the long term and, obviously, hopefully avoid any type of tragedies like with Deamonte. And I appreciate the work that the universities are doing. It was great to hear that. I think I got the numbers, 3 million you said.

Dr. CATALANOTTO. Three million dental visits across the 59 dental schools. That does not include any visits that might have occurred at——

Mr. JORDAN. In a year.

Dr. CATALANOTTO [continuing]. Dental hygiene programs.

Mr. JORDAN. Wow. You said at your university you had 100,000 last year.

Dr. CATALANOTTO. 100,000 visits, 76 percent of which were patients at 200 percent of the poverty level or below.

Mr. JORDAN. 100,000 children?

Dr. CATALANOTTO. No, 100,000 dental visits. There were 26,000 children of that 100,000.

Mr. JORDAN. We appreciate all that.

Dr. Edelstein, in your comments you said three things—paperwork, low reimbursement rates, and noncompliant patients—make it tough for certain providers to do this care. Which of the three is the one that—if you had to rank order those three, which is the one that is the most difficult for dentists to deal with?

Dr. EDELSTEIN. The one that is perceived and reported to be the most difficult is the low reimbursement, and the point I had hoped

to make clear is that sufficient funding is a necessary but not sufficient condition.

Mr. JORDAN. Would it help—let me ask you this question. I am going to ask some fundamental questions here.

Would it help if dentists would be able to—for those families who can pay something, would it help if they could say, OK, Medicaid covers this much and would you as a family be willing to pay X amount of dollars to cover the cost of the care? Would that help?

Dr. EDELSTEIN. I have no idea, except to suggest that it would create a significant—as small business people, it would create significant billing hassles and problems trying to deal with the copayments. As a practitioner who actively participated in both Medicaid and CHIP in Connecticut where copays were allowed for some CHIP patients in Connecticut, we did confront significant problems with trying to manage that cost-sharing portion.

Mr. JORDAN. OK.

So, again, you started—I think you were starting to say that what you hear typically is low reimbursements is the single biggest reason given for not accepting these patients. But it sounds to me like that's not what you believe. What do you believe?

Dr. EDELSTEIN. Well, the "but" was that our study nearing completion now tried to assess the impact of different levels of fee increase on utilization; and what we discovered were a couple of things. First off that with the increases, generally, you have the same providers who were already seeing Medicaid patients seeing many more Medicaid patients, rather than bringing a lot of new providers into the actual provision of care.

Now, that's when fees are the primary intervention. As Dr. McIntyre mentioned, in Alabama, there was additionally some case management and reductions in paperwork with prior authorizations. So a multi-pronged approach did help.

On the other hand, even in Alabama, with all of its tremendous effort, we see that relative increase was tremendous, but we still hit the same sort of barrier, hitting the top levels that any States have hit in the 40 to 45 percent range. And it's tempting to think that barrier really represents parents' failure to pursue care, but, in fact, parents are able to obtain significantly higher levels of medical care, raising the question about whether the doors to the dental offices are truly open.

Mr. JORDAN. OK. What—you mentioned noncompliant patients as one thing here. Do you think that's a real problem or not?

Dr. EDELSTEIN. Well, the noncompliance has to do with appointment keeping; and I think Dr. McIntyre explained how complex some of these individuals' lives are. But there's an excellent example that I cite in my written testimony from New York State, Tompkins County, where a county level care coordinator liked what the American Dental Association has suggested, as the community dental health coordinator acted as a case manager.

Mr. JORDAN. Let me just ask this question of all of you and see what you thought. And I brought this up, I think, in the very first round of our first panel.

You know, there are all kinds of taxpayer assistance that the typical Medicaid-eligible family receives. I kind of come from the school of thought that says, if you want responsible behavior, you

should reward it and irresponsible behavior, there should be some kind of penalty for it.

Do you think it would make some sense if, in fact, parents aren't complying with the appointments that they have, aren't doing what needs to be done for their kids relative to dental care, if there was some kind of sanctioning or some kind of penalty in—you know, typical families getting nine or ten different types. They are getting TANF. They are getting housing. They are getting food stamps. On and on it goes.

Some kind of sanctioning process, do you think that would be helpful, along with what Dr. McIntyre, I think, and Dr. Berg referred to in a previous answer, the care coordinator and the case manager approach as well?

Let's go down the line.

Dr. EDELSTEIN. I personally am more of a carrot than a stick person, thinking that as soon as there is a clear understanding of what the child's needs are that there be an effort to engage the family in a positive way. My concern is the child and recognizing the complexity of some of these lives to get to whatever benefits the children.

Mr. JORDAN. Yes. It seems to me—look, I know we did well for reform in the State of Ohio. I was the guy who did the language on the time limits component, and we said we are going to make sure kids get health care. We are going to make sure kids get, you know, the food they need. But at some point, if an individual is not willing to work and they are an able-bodied adult, they are no longer going to receive cash from the taxpayers. And it was a long period of time, and we gave them job training and everything else.

But at some point if you don't have that deadline, if you don't have—I would say deadlines influence behavior. And if you don't have that out there as some kind of thing that everyone has to think about—we all have to function. Everyone in the world has to function under those kinds of responsible things and those kinds of deadlines. It seems to me there might be an approach in there that can work and still make sure that these kids get what they need.

Dr. EDELSTEIN. Perhaps when dental access is readily available, when those office doors really are open and parents can have success in pursuing their desire to find treatment for their kids, then perhaps it would be time to think about the sticks.

Mr. JORDAN. Mr. Chairman, if I could, real quick——

Mr. KUCINICH. If you can give a quick answer.

Mr. JORDAN. I thank the chairman's indulgence.

Real quick——

Mr. KUCINICH. Just give a brief answer.

Dr. MCINTYRE. From the standpoint—I am like Burt. I look at the carrot versus the stick. And the reality is that sanctions will really hurt the children. Because what we are looking at is you are sanctioning the parents for behavior that the kids have no control over. And then what happens is they don't get into care. So really it would only hurt them.

Mr. JORDAN. The only thing I would say is——

Dr. BERG. I would agree with the last part of Dr. Edelstein's statement as well, that when the access problem is solved and there is much more readily available access, then we could look at

some pilot projects perhaps to study that. I think we don't have enough information to know if it's effective or not. I would want to study it on a small scale to see what kind of effectiveness we have.

Dr. CATALANOTTO. Just to emphasize that, in Florida, for example, only 10 percent of Florida dentists see Medicaid patients. Our numbers are worse than the rest of those States. We only have 25 percent of children achieving any kind of dental visit.

So until you solve the access problem, it's not—I don't think it's appropriate to talk about punishment for the parents, which ultimately punishes the child. We need to fix the access problem first.

Mr. KUCINICH. I thank the gentleman.

The Chair recognizes Mr. Cummings.

Mr. CUMMINGS. Dr. McIntyre—thank you, Mr. Chairman.

Tell me, what part did—first of all, the folks who you all hire, are these a lot of community people? In other words, that have the kind of sensitivity that you are talking about?

I think they first have to understand—it really reminds me of Healthy Start. In other words, you have people who understand the complexity of people's lives. They understand that punishment is—I could have answered that question. That's not going to get it, because then they will drop out of the system.

Dr. MCINTYRE. They will.

Mr. CUMMINGS. But so you must be—you must look at a certain type of worker who has a certain level of sensitivity.

Dr. MCINTYRE. We didn't hire anyone. Let me get that straight. This is—remember when I talked about public-private partnerships? We actually worked with the Health Department to get care coordinators in the community.

Mr. CUMMINGS. I see.

Dr. MCINTYRE. So that many of these people were folks that knew people already, that people were comfortable with. They were at the community level. They were on a county level. So that when you are calling to get a child in that a lot of times these people really know who the children are.

Mr. CUMMINGS. I see.

Dr. MCINTYRE. So I think in that standpoint we didn't go out and hire a bunch of people. We worked with the Health Department to get care coordinators at the county level in order to work to put this program into place.

And that's the whole thing about working together with all of the different entities within the State. It's not just a Medicaid issue. It's an issue that involves the entire State, and it involves all the people that are there coming together to try to come up with a solution.

Mr. CUMMINGS. Dr. Edelstein, we were talking about the whole idea of—you were here earlier when we talked with the other panel about this whole idea of a campaign to educate parents with regard to the significance of dental care for their children. Tell us, how do you feel about that? I mean, do you think that is very significant?

Dr. EDELSTEIN. Yes. The parents clearly have a critical role, particularly, as Dr. Berg mentioned that the disease onset is very early in life. And so we need to get to parents very early in life, as required now by CHIPRA.

But one of the roles for the parents is the day-to-day, moment-to-moment decisions that they make that either predispose their kids to have this problem or predispose their kids to avoid this problem. And so the education needs to be about more than dental care but has to be about managing the risk factors for developing the disease in the first place.

Mr. CUMMINGS. You know, I visited Kennedy Krieger in my district. They have this clinic for severe dental problems for kids, and they showed me some kids who had had phenomenal damage as little kids. I mean, who literally had to go through major surgery as a little kid—I mean, like 3 years old—because of things like a bottle with sugar, like juice bottles, and the sugar gets to the tooth. And a lot of people don't realize how significant those little things are. And I just think that education is so significant.

The other thing I was going to ask you about is these federally qualified health centers. One of the things that I pushed hard for is making sure that they could contract with dentists. Because a lot of times that's a missing piece, and those help centers are located smack dab in the middle of places where people would not normally be able to get health care.

You might want to comment on that, too, Dr. McIntyre——

Dr. EDELSTEIN. Well, if I might reflect on the value of that contracting, it has so many values. The first is that it allows dental practitioners who are not Medicaid providers to contract with FQHCs to see Medicaid patients and thereby become familiar with the patients as people, as patients who they can become more comfortable with and discover really face the same kinds of dental issues that others do and can be readily accommodated in their practices.

The second is that it expands the capacity of the federally qualified health center. So many of the health centers are limited either by not having dental facilities themselves or having facilities and no dentists, because there is a shortage in the FQHC system. So that allows them to contract with dentists to expand their capacity.

So, on both sides, it benefits the patients, it benefits the dentist, it benefits the health centers. And we anticipate that experience the dentists will have will lead them more likely to become active Medicaid providers.

Mr. CUMMINGS. Dr. McIntyre, did you have a comment on that? And thank you.

Dr. MCINTYRE. Yes, I wanted to comment that, in looking at the public-private partnership, the FQHCs are vital in making sure that we identify all of the resources available.

And some of the things we did was also identify not just the Medicaid dentists per se but also for uninsured—because a lot of our uninsured go on and off, you know, their own Medicaid; then they have no insurance at all—to make sure that those resources are available for them.

But there is a shortage. When we talk about addressing access issues, one of the things I wanted to bring out was this: Overall, in our State, as of May, we had a shortage of 288 dentists. Now this is not Medicaid dentists. This is a shortage in dentists in the counties.

So, in addressing the issue, we have to address the work force in order to—like, he was talking about are their doors really open? Well, the doors are open, but who gets in it to see is something that you have to consider when you are looking at that. Because the work force itself is part of this problem.

Mr. CUMMINGS. Thank you.

Mr. KUCINICH. I thank the gentlewoman.

The Chair recognizes Mr. Issa.

Mr. ISSA. I thank the gentleman.

I thank the chairman for holding this hearing, because I do believe it is important that we as a committee that looks at waste, fraud, and abuse also look at government efficiency; and that's, I think, a great deal of what we want to work on here today.

Before I do my comments, I would like to yield to the gentleman from Ohio for his question.

Mr. JORDAN. Well, just a quick comment, and I do have to run to an RC thing.

I could tell the panel didn't particularly like my suggestion about holding parents more accountable. But I would just point out this. We heard from the previous panel that the number was one in three kids, 33 percent, were getting the treatment, according to the study done in 2008. And since that time Ms. Mann's answer was it has been improved all the way up to 36 percent now.

So, obviously, what we are doing isn't working. Maybe it makes sense, you know, to try the same old, same old, giving us the big increase of 3 percent. Maybe it makes sense to try something different and go the route that I suggested. That's my only point. I know it's worked in other parts of welfare reform. It has worked in the State of Ohio.

So I would just offer that and thank the gentleman for yielding me a few seconds.

Mr. ISSA. Now I am going to take a slightly different line of questioning.

I guess I have an MD, a DMD, and two DDSs, so that probably gives me all of the passel of opinions.

When I was growing up in Cleveland, Ohio, right next to but slightly down the street from the chairman, we still had a great deal of, if you will, the public health care system; and a lot of the services at that time were delivered through nonprivate means if they were going to be delivered. I got my shots through the public system and so on. And that delivery system for the working poor and even up tiptoeing through the middle class and certainly for what we would call the most indigent among us today was an accepted part of society.

It appears to me as though, as we have divested ourselves of that, and the Medicaid system has been about money being delivered, often, often not at the same rate, haven't we moved away from—at least germane to today—if preventive medicine, recognizing that dentistry expands to fill the amount of money you have, that if you have enough money—and we here on the dais don't have a dental plan—or at least it's not standard in our program. If you have enough money, you don't get amalgam. If you have enough money, you don't get false teeth; you get implants. If you have enough money, you go through a series of much more expen-

sive levels of care. And I think you are all aware of just how phenomenal dentistry can be if you have the dollars for it.

But aren't we here today talking fundamentally about the least—trying to find the most efficient, least expensive, most universal for the poor delivery of evaluation, cleaning, and prevention? And isn't our system somewhat broken in that if that's what you wanted to provide, would you provide it the way you do today? And this is regardless of 3 percent more money, 6 percent less money.

I would like your comments on that. Because, for this committee, we do try to think in the sense of organization of government.

I will go right down the line. Thank you, Doctor.

Dr. EDELSTEIN. Interestingly, this problem is not unique to the United States; and underserved populations having lack of dental care is a global phenomenon. So if we look at other countries like ours—Great Britain, New Zealand, Australia, the Netherlands—to see how they have approached this, they do it primarily with the advent of different kinds of providers. I wouldn't say that it's necessarily a public delivery system, as opposed to a private delivery system, but it's a more readily accessible, more limited in scope provider who is more like the vulnerable population being treated.

And there are a number of ideas, from the American Dental Hygienists Association, the American Dental Association, new legislation in Minnesota, experiments and new programs in Alaska, a variety of approaches that bring dental therapists to increasing the capacity for the delivery of services. So, looking at other countries, that might be one direction of particular value.

Mr. ISSA. As you go down the list, the reason I said "public" is that I understand that dental practice and State regulations tend to predetermine certain things such as a hygienist being able to work on their own or not, an assistant work on their own or not. I used the term "public" because it's a preemption for the poor potentially that would allow us to find the most efficient way to provide preventive medicine that might not be universally available in some States. Being in California now, I am aware of that.

Please, Doctor.

Dr. MCINTYRE. Well, as a physician, one of the things that I started out with our group, when we first formed our task force in our coalition, was that the mouth is part of the body and that for some reason we have kind of separated it out and I think a lot of problems came from that.

But we have actually started using our primary care providers, physicians, more because dental caries is a disease and, like any disease, in order to get away from the disease later, we have to prevent it. So if we can start early, when children first get their teeth—you know, when they get those first two in the mouth, even before they get their teeth, we start educating mothers when they are pregnant about what they need to do. They get brochures and information from the care managers about how to take care of the teeth and the babies aren't here. They are more likely to listen before the babies are born. Then when they get here, then doctors who see children and give them their shots is an ideal opportunity to educate, assist, and refer; and that's what we are trying to do to utilize the system.

Mr. ISSA. If we could narrow the answer just to the organizational one, because I am testing the chairman.

Mr. KUCINICH. Please respond, the gentleman's time has expired.

Dr. MCINTYRE. And that is part of the organization.

Mr. ISSA. Thank you.

Dr. MCINTYRE. Using physicians to do part of the work, OK.

Dr. BERG. My comment is a summary of what has been stated before. That dental caries, cavities in kids is almost entirely preventable; and the earlier you intervene, the more preventable it is. And the other nondental providers who aren't treated in the surgical aspects of dentistry can assist us in the risk assessment of prevention. You know, the fluoride varnish is not the cure. But the risk assessment, determining who is at greatest risk and providing more aggressive and frequent interventions, that is the solution.

So I think we need to segregate the surgery and not think about dentistry as surgery. We have dentists who can do surgery. We need some assistance in the earlier intervention for those folks, as mentioned, who do see the children earlier.

Mr. ISSA. Thank you. Please.

Dr. CATALANOTTO. The other part that I would mention about this is that there is a fundamental problem, though, in the dental public health infrastructure. What I mentioned in my testimony is that, assuming you had, at full capacity, the existing public health infrastructure, the dental institutions, county health departments, federally qualified community health centers, they can only address about 8 percent of the dental need that's out there.

So part of your solution that you need to look at is improving the dental public health infrastructure.

Mr. ISSA. Thank you. Thank you for your indulgence, Mr. Chairman.

Mr. KUCINICH. Thank you.

The Chair recognizes Ms. Watson.

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

I want to address this particularly to Dr. McIntyre and Dr. Berg. I think your two States have participated in some promising practices that were posted by CMS; and, in a survey that was taken by GAO, there were 37 States who indicated a need for more information on other States' efforts. And have you then shared that information? Have you been part of it, Promising Practices, that was initiated by CMS? And can that Web site then be promoted to other States that need this information?

Dr. McIntyre.

Dr. MCINTYRE. Well, we have actually provided information to a number of people, including CMS.

Now, as far as whether it's part of the Promising, I know that we have actually published articles. We put out information on our Web site. We mailed out brochures to all 50 States. It's, you know, basically in the past, to actually give them the information about what we were doing. So—and we actually put the information where it is accessible, and we are willing to share it with anyone.

Ms. WATSON. One of the things that concerns me is that many of the dentists kind of look at the Medicaid beneficiaries and say, I really don't want them. What's with that attitude?

Dr. MCINTYRE. I mean, I think that's a matter of education as well; and it goes on both sides. Part of what we did as part of our provider education and outreach was to educate providers that it was a two-way street. And that in order to receive, you know, the behavior that they were expecting, they also needed to be willing to treat people with respect. So we came up with a dental rights and responsibilities sheet that addressed the provider on what they could expect and what the patient could expect from the provider and for both of them to sign it.

And the reason for that is—and I am saying this because, as a child who grew up with no insurance and no access to health care, OK, and people a lot of times are looking down on people just because of their income levels, is something that we have to go beyond. And that is one of the things that we address with the providers, that, you know, if you expect people to behave a certain way, you have to treat them so that they will behave that way. If you expect bad behavior, you will get bad behavior. So that's part of the education that we deal with our dental task force.

Ms. WATSON. Dr. Berg.

Dr. BERG. Yes, I think, part of the success of ABCD is training and cultural sensitivity. That's a big part with the staff, and it's effective. You know, that there are unique needs of this different population, their circumstances are different, and that has been critical to the success. So I will just add that statement.

Ms. WATSON. Well, let me give you a pet peeve of mine.

I had a bill for the last 8 years to look at dental amalgams. Amalgams are, as you know silver fillings. They are 50 percent mercury. Mercury is the No. 1 toxic element. And I have been getting to the dentists. In fact, the minority dentists came in, and they are adamantly opposed to it because they say it's cheaper to put an amalgam filling in.

Well, the research shows that when you have mercury in your fillings, it is constantly—gases are constantly escaping, particularly with children. So I find a real problem with the dentist that says to me, it's a matter of cost. And, you know, we have now, in your States, Medicaid providing dental health care; and then we don't have this kind of patient result. However, when you get the industry saying to you, it's a matter of cost, black people don't like to go to the dentist, so this is the cheapest we can give, I think that's a violation of ethics. How do we continue to educate these dentists? Anybody want to take a swipe at that?

Dr. BERG. You are talking about the amalgam question specifically?

Ms. WATSON. Yes.

Dr. BERG. I think, first of all, to remind them that only about 6 percent of their total cost is materials, including amalgam and other materials; and the real cost is how efficient they are at running their practice. And I think there are best practices and ABCD has an annual meeting where our champions come together and talk about how do I run efficiently in my office. And by changing those behaviors in their office, they can do well by doing good and be much more efficient. So I think that's the focus we give.

By the way, I think, in our State, I wouldn't say there's any differentiation in any population in terms of who gets what, restora-

tive procedure. We don't happen to do many amalgams, because there are alternatives today. Some do. But I think we like to educate that it's the efficiency of running the practice where they are going to save the money, not—difference of materials are really minuscule compared to staff costs and other costs in the practice.

Ms. WATSON. Thank you.

Thank you, Mr. Chairman.

Mr. CUMMINGS [presiding]. Thank you very much.

We are going to conclude this hearing. But I want to thank all of you for your testimony.

As a representative from the State where Deamonte Driver died, this hearing means a lot. I have often said that Deamonte Driver was a little boy who was suffering from an infected tooth, and he died in one of the richest States in one of the richest counties in one of the richest countries in the world. There is something wrong with that picture, and we can do better.

Dr. McIntyre, I was just thinking, as you were talking about this whole idea of people just getting respect, a lot of times people don't realize it, but people feel so often that folks are talking down to them, and they don't—so they don't—they feel that they are not respected.

When we look at health care disparities, for example, one of the things that is clear is that there is a divide and some type of misunderstanding between, sometimes, those people who are trying to treat and those who need treatment. And so I think it's very important that, when we look at the Deamonte Drivers, we look at all the kinds of things you have talked about here today.

And I was glad that Ms. Mann stuck around to hear some of this.

One of the things that Ms. Mann said was—not Ms. Mann but our gentlelady, Ms. Iritani, said was that they wanted—these other States wanted to know best practices. Duh. I mean, this is not rocket scientist stuff. This is basic common sense and trying to work things out and treating human beings as human beings.

So I just kind of think—I know we made a lot of headway, but I just wanted to take the time to thank all of you all every day because you are affecting children.

I mean, and I say over and over again, children come on this Earth with gifts. They bear gifts. Every one of them bears gifts. They are born on the day that they are born to deliver gifts at certain points in their lives. But what happens is that, if we don't treat them right and we don't nurture them and nourish them and help them develop, they will never deliver those gifts. And if they are sitting, as I did as a little boy, sitting in elementary school thinking that cavities was a part of life. It wasn't a question of—it was like a headache. You are supposed to have cavities. And a lot of people are still thinking that today.

That's why this whole education thing is so significant, letting people know. And that whole idea of letting them know there is a direct relationship between the body and teeth, they don't think it.

So I think all of us—I mean, the testimony that you all have provided today is basics. And, hopefully, somebody is listening, somebody will come to you all—because you all seem to know where you are going, and you are on the right path—and allow you to help others to get it.

Now, the question becomes sometimes not whether people get it but whether they want to get it, whether they have the will to do what's necessary; and that's where we are going to come in. We are going to try to do everything in our power to make sure that our children, that the providers, that the States, and that all others have the kind of information they need so they can touch our children in a positive way and look out for generations yet unborn.

Finally, let me say this. This is about—this is bigger than us. This is bigger than us. When you were talking—Dr. McIntyre talked—you know, it's a great idea to educate mothers before they give birth. Because, you know, all that excitement you have when you find—you know, I am not a woman, so I don't know, but folks get real excited about their first birth in particular. And they go and they prepare the room and all that kind of good stuff.

And then the question becomes, you know, shouldn't part of that preparation be making sure that you are prepared for the teeth of that child and the dental health?

And what I was telling my aide, you know, was that the wonderful thing about it was that if you then educate, first, the mother delivering the first child, then that sets a pattern for the other children that may come. But it does something else. It then teaches the child as the child grows up how to take care of their teeth and then hopefully generations—you have generational cycles of good teeth, taking good care of your teeth. That's what it's all about.

So thank you all very much. This hearing is now adjourned.

[Whereupon, at 5:05 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

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Center for Medicaid and State Operations

NOV - 9 2009

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

Dear Representative Kucinich:

This letter is in follow-up to the October 7, 2009 Subcommittee on Domestic Policy hearing on Medicaid Dental Services, and reflects our commitment to keep you apprised of our activities with respect to improving dental and oral health services for children. The Centers for Medicare and Medicaid Services (CMS) has followed-up with the 16 State dental programs that were reviewed in 2008, which we referenced in our October 23, 2009 letter to you. We wanted to evaluate the progress of the States and assess what further steps are needed to improve children's access to dental care in these States.

Each of the 16 States reviewed have taken action to address the issues identified in the review process based on the recommendations CMS provided. Specifically, program changes in the reviewed States include the development of separate dental periodicity schedules; one State removed limits on dental services provided to Medicaid eligible children; and several States made changes to contracts to improve the adequacy of their networks. In addition, based on CMS' recommendations, several of the States have created separate dental fact sheets that are provided to all Medicaid enrollees outlining dental benefits and periodicity schedules.

Given that these program changes are still new, the full impact of the changes are not yet known. However, eight of the sixteen States reviewed (AR, DC, GA, LA, ND, NJ, NV and NY) have seen increases in the rate of children receiving a dental service by at least 5 percent from 2006. Two of these States, North Dakota and Nevada, have increased the rate of children receiving a dental service by 10 percent from 2006. Six States increased their utilization rates by between 1-4 percent (CA, DE, MI, MO, MT, and WI). The rate of children receiving dental services in the two remaining States, Florida and Pennsylvania, has remained stagnant at 21 percent and 27 percent respectively. There are currently eight States that continue to have utilization rates at or below 30 percent; each of these States were part of the 16 State dental reviews.

Further improvements in utilization of dental services appear to be hampered by a persistent set of challenges. Below is a description of some of key problem areas with some examples of States that have made progress since the reviews began:

1) Availability of Dental Providers
   Many States are experiencing difficulty recruiting dentists to serve Medicaid and Children's Health Insurance Program (CHIP) patients, which is often due to the relatively low number of overall dentists serving the entire population. New York has been working closely with the New York State Dental Society to identify providers for their recruitment program. These efforts have resulted in close to 100 additional dentists and

specialists being enrolled. The State also implemented a tracking system to help them better understand the reasons that dental providers do not enroll in the Medicaid program. Other States have made efforts to improve access to dental services by encouraging other providers to offer oral health services. Michigan updated its policy to allow medical providers to be reimbursed for applying fluoride varnishes on children under the age of three, thereby improving access for young children to oral health services.

2) Administrative Burdens
Many of the reviews indicated that providers felt there were too many administrative barriers to overcome when providing service to the Medicaid population. The reviews indicated that providers object to the prior authorization processes, lengthy provider applications, and the lack of reimbursement for missed appointments. In order to address these issues, Pennsylvania has undertaken administrative modifications such as streamlining prior authorizations. In addition, Arkansas has hired a new full-time dental consultant to address the workload issues, consistency, and timeliness of prior authorization determinations.

3) Reimbursement Rates
Low Medicaid reimbursement rates continue to be one of the main reasons that providers do not participation in the Medicaid program. Pennsylvania has undertaken multiple initiatives including implementing pay rate increases and pay for performance standards, though as noted earlier, the State has not yet seen an increase in utilization due to these efforts.

4) Transportation
Transportation has also been n issue in several States. Several States have made efforts to evaluate and improve the availability of transportation services as a result of the reviews. For instance, Montana has utilized a number of methods to highlight the availability of transportation services including: updating its client handbook and provider manuals, developing wallet cards and posters providing a toll free number for assistance and describing the transportation benefit. As a result, Montana has seen an increase of 34 percent in the use of transportation benefits to access dental care. However, one State of the 16 reviewed continues to have unresolved issues regarding the appropriate provision of transportation services. CMS will take further action, including the issuance of a formal corrective action plan, if necessary.

5) Communication to beneficiaries about their benefits
The reviews found that many States did not communicate regularly with beneficiaries about their dental benefits. Delaware has identified a way to address this issue. The State directed its Managed Care Organizations (MCO) to ensure that the MCO notified beneficiaries of the available dental services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit package. Delaware's utilization rate has increased by more than four percentage points from 2006 to 2008 as a result of these actions. CMS will continue to work with other States to ensure beneficiaries are informed of their benefits.

As the Government Accountability Office (GAO) has noted, one of the most effective ways CMS can help improve dental utilization rates is to identify steps States have taken to improve

their rates. In an effort to identify more best practices, CMS will begin additional Medicaid dental reviews before the end of the calendar year for State programs that have achieved high dental utilization or have been identified as having innovative programs.

CMS will continue to provide the Subcommittee with updated information as we continue to develop and move forward with our efforts to improve children's access to dental care in Medicaid and CHIP.

Sincerely,

Cindy Mann
Director

cc: The Honorable Jim Jordan
The Honorable Elijah Cummings