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Hearing on Oversight of Dental Programs for Medicaid-Eligible Children

Good afternoon. My name is Jane Perkins. I am the Legal Director of the National Health Law Program, an organization working at the local, state and national levels on behalf of working poor and low-income people. I have been at the National Health Law Program for over 22 years, focusing on children's health and public insurance, particularly Medicaid.

My testimony today addresses the performance of states in assuring that children obtain dental services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program—a mandatory benefit for children and youth under age 21. I will also discuss the role of managed care organizations (MCOs) in the provision of EPSDT dental services and oversight by the Centers for Medicare & Medicaid Services (CMS) in assuring that states operate their programs in compliance with the Medicaid Act and implementing rules.

States' performance. The Subcommittee has heard the story of Deamonte Driver. The problems highlighted by his story are not unique to Maryland.

Congress requires states to report to CMS annually on the number of children receiving dental services.[1] States are to use a uniform reporting form, called the CMS-416, to collect and report the data. In the states reporting in FY 2004 (seven states are missing), only 30 percent of children received any dental services, and only 22 percent had a preventive visit. Even fewer children, 16 percent, received any dental treatment services. There was significant variation according to the child's age and the state where the child lived.[2] *Please note*: Although CMS has released CMS-416 data for FY 2005, it was not used for this testimony because 15 states' reports are missing. Examples from individual states help explain the national data:

- In California, our office serves as the lead agency for the Health Consumer Alliance (HCA), a partnership of independent consumer assistance programs in thirteen counties that are home to over three-fifths of California's low-income residents. Together with the Health Rights Hotline in Sacramento, HCA responds to approximately 1,400 requests for assistance each month. Since its inception nine years ago, access to dental care has remained among the top five service problems for which beneficiaries seek assistance from HCA. A 2002 study found that denial of essential dental services was the number one problem for

beneficiaries who called about dental issues (32 percent of the services problems). Other frequent problems involved delays in obtaining authorization from the State or MCO for dental services, difficulties obtaining specialized treatment, quality of care, language barriers, and misunderstandings among providers and MCOs about what dental services EPSDT covers (e.g. medically necessary orthodontia to address handicapping malocclusions—for example, a nine-year-old who needed orthodontia to address a significant overbite which caused her lower incisors to cut into the soft tissue of her upper palate).[3] California's dental utilization rates, as reported on the CMS-416, are among the lowest in the country.

- According to a June 2003 report from the Court Monitor in the ongoing *Salazar v. District of Columbia* case, "substantial evidence indicates that the majority of eligible children in the District's EPSDT program are not receiving adequate dental care."[4] The Medicaid Act requires each Medicaid-participating MCO to assure CMS and the State that it maintains a sufficient number, mix and distribution of providers.[5] However, there have been problems verifying the extent of dentists' participation in the District's program. In March 2005, the District provided a list of participating dentists to the *Salazar* legal counsel. Counsel surveyed dentists on the list. Of the 135 unduplicated dental providers named, only 45 individual dentists and one clinic confirmed that they accepted Medicaid-eligible children. Of the 45 dentists, 29 were general dentists; six, oral surgeons; three, pediatric dentists; and one, an orthodontist (with the remaining 6 dentists unidentified by specialty). The other 89 dentists or dental offices were no longer serving Medicaid clients, had moved, had closed, or numerous attempts to make contact were unsuccessful. In March 2006, the District submitted an updated list. By counting each name only once (a number of dentists were enrolled in more than one MCO and in fee-for-service), a total of 63 dentists, nine oral surgeons, and one orthodontist were available to treat all EPSDT eligible children in the District (over 90,000 children). Notably, these data say nothing about the extent of dentists' participation, for example whether the dentist is accepting new Medicaid patients or limiting the number of children served.

- In Miami-Dade County, a pilot project proposed by Governor Bush and approved by CMS in record time has enrolled Medicaid children in a dental home and pays a per member per month amount for each child. A report from the State's contractor, the University of Florida Institute for Child Health Policy, found that the number of children who received dental care through the Medicaid program dropped 40 percent during the first year. Only 22 percent of eligible children visited a dentist, compared with 37 percent under the old fee-for-service system. The number of participating dentists declined from 669 to 251. Other reports showed a dental group, which was paid $4.25 a month for each of 790 children, provided services to only 45 (5.7 percent) during the first six months of 2005. Thus, the group was paid $20,145 for treating 45 children.[6] An analysis from the College of Dental Medicine at Columbia University found that costs under the program stayed about the same and that the State of Florida lost value by paying the same amount for less care and less quality.[7]

A handful of Medicaid programs have targeted children's oral health services and increased utilization. These efforts, in states such Alabama, Georgia, Indiana, South Carolina, Texas, Vermont, and Washington, share some common features: First, adequate payment levels tied to dentists' usual and customary charges and commercial products in the state; second, administrative changes that streamline the program; third, appointment of a high level committee or departmental position to focus on problem solving; fourth, effective outreach and marketing to beneficiaries; and fifth, case management to address appointment no-shows. For example:

- Alabama reported a 68 percent increase in children's utilization of dental services between FY 2001 and FY 2005 after it launched *Smile Alabama!,* an initiative that included a public awareness campaign, dedicated personnel to assist dental providers with administrative issues, recruitment efforts led by the governor, and a payment increase in 2000 to match BlueCross/BlueShield of Alabama rates.

- In South Carolina, shortages of dentists resulted in few providers being available to care for Medicaid-enrolled children. South Carolina developed an initiative to train general dentists to expand their practices to treat pediatric and special needs children. Payment rates were increased to the 75th percentile of rates in the region, resulting in a 73 percent increase in the number of participating providers. The State also addressed recipient outreach. One campaign partnered with the African Methodist Episcopal Church to offer dental screening at more than 110 events. Patient navigators were used to assist families in scheduling appointments, and more than 85 percent of those families kept their follow-up appointments.

- Virginia recently transitioned its delivery of dental services out of capitated managed care and back to the fee-for-service system. This move, coupled with additional changes (e.g. a 30 percent increase in dental rates and dentist recruitment and retention strategies), resulted in 76 additional dentists enrolling in the program between July and November 2006. There was a 43 percent increase in preventive services and a 75 percent increase in restorative services delivered to Medicaid-eligible children between SFYs 2005 and 2006.[8]

CMS' efforts at oversight. CMS has known for at least 15 years that Medicaid-enrolled children are not receiving the dental care that they are entitled to through EPSDT. CMS has been repeatedly told that there needs to be increased review and monitoring, particularly in states contracting with MCOs.

In August 1992, the Office of Inspector General (OIG) recommended that, "The HCFA [now CMS] should enhance monitoring procedures to assure the accuracy of states' reporting," a recommendation with which HCFA concurred.[9] Five years later, the OIG noted the failure of managed care plans to cover mandatory EPSDT services and again called for "increased review and monitoring by HCFA, especially among States with mandatory managed care enrollment."[10] On January 18, 2001, the federal agency, citing a Government Accountability Office (GAO) study, notified State Medicaid

Directors that overall utilization of dental care by EPSDT-eligible children remains low. The agency told states of its intent to increase oversight and informed them that "it is especially important to assure that dental utilization data are obtained by the State from the managed care organizations."[11] If children's dental visits fell below 50 percent of eligible children, the state was to submit a plan of action for improving access. At least 45 states and the District of Columbia submitted plans. Although the January 2001 letter made suggestions to states for improving utilization and informed states that CMS would be conducting investigations, there does not appear to have been significant follow up.

The OIG, GAO and HCFA have all also noted the importance of accurate reporting on the CMS-416. This form provides valuable information about each state's EPSDT performance, annually and over time. It also provides information to CMS about whether the mandates of the statute are being met. CMS revised the reporting form in 1999 and, among other things, improved the required reporting for dental services. However, there does not appear to have been any significant follow up by CMS when states submit forms showing that children's utilization of services is low. For example, looking back over the last seven years, our office has not located any Notices published by the federal agency in the *Federal Register* that refer to enforcement actions using the CMS-416 or that announce that a state Medicaid program was being sanctioned for failing to provide dental services to needy children.

Notably, the Medicaid Act provides that the Secretary of the Department of Health and Human Services shall annually develop and set participation EPSDT goals for each state.[12] Given the increased use of managed care and the stated role of managed care to provide children a "medical and dental home," it could be expected that the Secretary would annually increase the participation goals for each state. However, the last time the Secretary developed and set annual participation goals was in 1990, when the goals called for each state to provide at least 80 percent of EPSDT recipients with timely medical screening by FY 1995.

When it revised the CMS-416 form in 1999, CMS issued detailed instructions to the states for completing the form. Nevertheless, we have heard complaints from some states and managed care organizations that the completed forms under-report the number of children receiving EPSDT services. When studies have occurred, however, they have usually confirmed the accuracy of the 416s.[13] The CMS-416, like all other uniform Medicaid reporting forms completed by states and submitted to CMS, represents each state's presentation of its activities, and as such, serves as an important indicator of state performance.

CMS has taken steps to provide information to states. The *Guide to Children's Dental Care in Medicaid* (Oct. 2004) includes information about how to organize and manage oral health care for children under Medicaid's EPSDT service. However, CMS says the guide is not intended to change current Medicaid policies nor impose any new requirements. Through the use of *Dear Medicaid Director* letters, CMS could address issues that we see regularly in our state-based work. For example, child advocates from Massachusetts have noted the need for clear federal direction that EPSDT covers case

management and transportation services to help avoid broken dental appointments. The provision of dental services in schools (the places where kids are) could be enhanced by clear federal direction supporting comprehensive dental care in schools and explaining how states can use Medicaid funding to pay for it. Child advocates in Missouri point out the need for CMS to issue and enforce guidance to assure adequacy of dental networks, stating that it is not uncommon for some families, especially in rural areas, to travel up to 200 miles to obtain dental care through their MCO. The provision of dental services is also affected by multiple contracting and subcontracting arrangements resulting in multiple layers of administrative costs being taken from the per member per month payment without assuring adequate pass through of funding to the dental care provider. Investigation of this problem by CMS could be beneficial.

CMS appears committed to privatizing quality monitoring by allowing states and MCOs to use private accreditation standards to measure performance. Standing alone, this is problematic. The private measures lack the degree of specificity required by the CMS-416. For example, the 2007 HEDIS includes only one dental measure—annual dental visit. By contrast, the CMS-416 requires states to report on eligible children receiving preventive, treatment and any dental services according to five age groupings. Moreover, by measuring only annual dental visits, the HEDIS is not measuring what Congress has required in the statute: dental visits according to schedules arrived at by the state after consultation with dental providers. Our review found that, as of May 2005, all but three states call for children to receive a dental exam every six months, not annually.[14]

CMS has recognized problems with the low dental provider participation and payment rates. However, CMS does not appear to have exercised its enforcement and oversight authority to require individual states to address these problems. Moreover, it introduced confusion about which laws apply to MCOs. Before 2002, the agency consistently said the "equal access' requirement, 42 U.S.C. § 1396a(a)(30)(A), applies to MCOs and requires state Medicaid payments to ensure that covered services are available to Medicaid recipients at least to the extent the services are available to the general population. Indeed, the Medicaid Act does not exclude MCOs from compliance with (30)(A). However, statements by CMS in June 2002 confused the point, hinting that the access requirement may apply only in fee-for-service settings.[15]

In conclusion, we appreciate the opportunity to report to you today. Children's dental care remains a neglected stepchild among health policy priorities. Unfortunately, poor dental health can cause pain and infection, contribute to poor digestion and diet, affect a child's speech and appearance, and can cause other serious health problems, including heart attacks, strokes and, in Deamonte Driver's case, death.

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[1] *See* 42 U.S.C. § 1396a(a)(43)(D) (West Supp. 2006).

[2] *See* CMS, *Annual EPSDT Participation Report Form CMS-416s* (Fiscal Year 2004), http://www.cms.gov; National Health Law Program, *Children's Health under Medicaid: A National Review of Early and Periodic Screening, Diagnosis and Treatment 1999-2003* at 17-21 (May 2005).

[3] *See* Health Consumer Alliance and Health Rights Hotline, *Denti-Cal Denied: Consumers' Experiences Accessing Dental Services in California's Medi-Cal Program* (Dec. 2002).
[4] *See* Henry T. Ireys, PhD, Court Monitor, Salazar v. District of Columbia, Civil Action No., 93-452(GK), *Methods Used by the District of Columbia and the Managed Care Organizations to Inform Recipients about Preventive Dental Services* (June 17, 2003) (citing the District's quarterly reports that only about 15 percent of eligible children received a dental assessment). The National Health Law Program serves as co-counsel for the children in this case.
[5] *See* 42 U.S.C. § 1396u-2(b)(5)(B), *see also* § 1396u-2(a)(5)(B) (requiring MCOs to provide, upon request, information showing identity, locations, qualifications, and availability of participating providers).
[6] *See* John Dorschner, *A new study reports that a pilot project in Miami-Dade to privatize the dental care of poor children resulted in a huge drop in treatment,* Miami Herald (Jul. 30, 2006); *see* Elizabeth Shenkman, PhD, Institute for Child Health Policy University of Florida, *Evaluation of the Miami-Dade County Prepaid Dental Health Plan Year 1 Baseline Report* (June 27, 2006).
[7] Burton L. Edelstein, DDS, MPH, Professor of Dentistry and Health Policy & Management, Columbia University, *Miami-Dade County Prepaid Dental Heath Plan Demonstration: Less Value for State Dollars* 3 (Aug. 2006).
[8] *See* Smiles for Children, Presentation to Dental Advisory Committee, *A New Day for Oral Health in Virginia* (Jan. 5, 2007) (emphasis is original).
[9] *See* Office of Inspector General, U.S. Dep't of Heath and Human Services, *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)—Performance Measurement* 9 (Aug. 1992).
[10] Office of Inspector General, U.S. Dep't of Heath and Human Services, *Medicaid Managed Care and EPSDT* (May 1997).
[11] Health Care Financing Administration, US Dep't of Health & Human Services, *Dear State Medicaid Director* (Jan. 18, 2001).
[12] *See* 42 U.S.C. § 1396a(a)(43)(D) (West Supp. 2006).
[13] *See, e.g.,* National Health Law Program, *Toward a Healthy Future—Early and Periodic Screening, Diagnosis and Treatment for Poor Children and Youth* at 44 & n.275 (Apr. 2003) (collecting studies).
[14] *See* National Health Law Program, *50-State Dental Periodicity Schedules* (May 2005), http://www.healthlaw.org.
[15] *See* 67 Fed. Reg. 40989, 41036 (June 14, 2002).