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

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

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

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

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

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

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

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

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

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

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

He went on to say:

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

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

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

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

- Rank the states in order of performance vis-a-vis the provision of dental care

- Ensure that administrators of Medicaid programs have ready access to the policy guidance they need in order to cover children's dental services with respect to reimbursement rates and managed care oversight

- Issue a letter to State Medicaid Directors reminding them of their legal obligations and ask them to submit "plans of actions" for ensuring that children will have adequate access to dental services

- Assess civil money penalties against any managed care organization that has contracted with a Medicaid agency and has failed to do so

What a difference a year makes.

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

But time doesn't heal all wounds.

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

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

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

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

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

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

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

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

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

We think that answer is unacceptable.

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

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

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

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

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

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

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

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

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

Today we will find out.

We are pleased the Mr. Smith is here today to testify about what CMS has done, but perturbed that he has not, as custom, seen fit to provide this Subcommittee with a written copy of his testimony in advance of the hearing.