WRITTEN TESTIMONY
Submitted by
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for the
U.S. House of Representatives
Committee on Oversight and Government Reform
Domestic Policy Subcommittee Hearing
On February 14, 2008
"One Year Later: Medicaid's Response to Systemíc
Problems Revealed by the Death of Deamonte Driver"

I, James J. Crall, D.D.S., Sc.D., hereby submit the following as written testimony pursuant to the Subcommittee's request for information in conjunction with a hearing scheduled for Thursday, February 14, 12007, at 2:00 p.m., in Room 2154 of the Rayburn House Office Building. My statements are organized into three sections corresponding to specific requests contained in a February 4, 2007 letter from Chairman Kucinich.

1. Discuss the Significance of Oral Health to Overall Health

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

Oral Diseases, Pathology and Developmental Disturbances Are Common Afflictions

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

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

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

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

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

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

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

programs -- via legislative authorization and appropriations, regulatory oversight and effective program implementation -- remains a significant detriment to overall health and quality of life for millions of U.S. children and adults.

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

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

Large Numbers of Children Enrolled in Medicaid

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

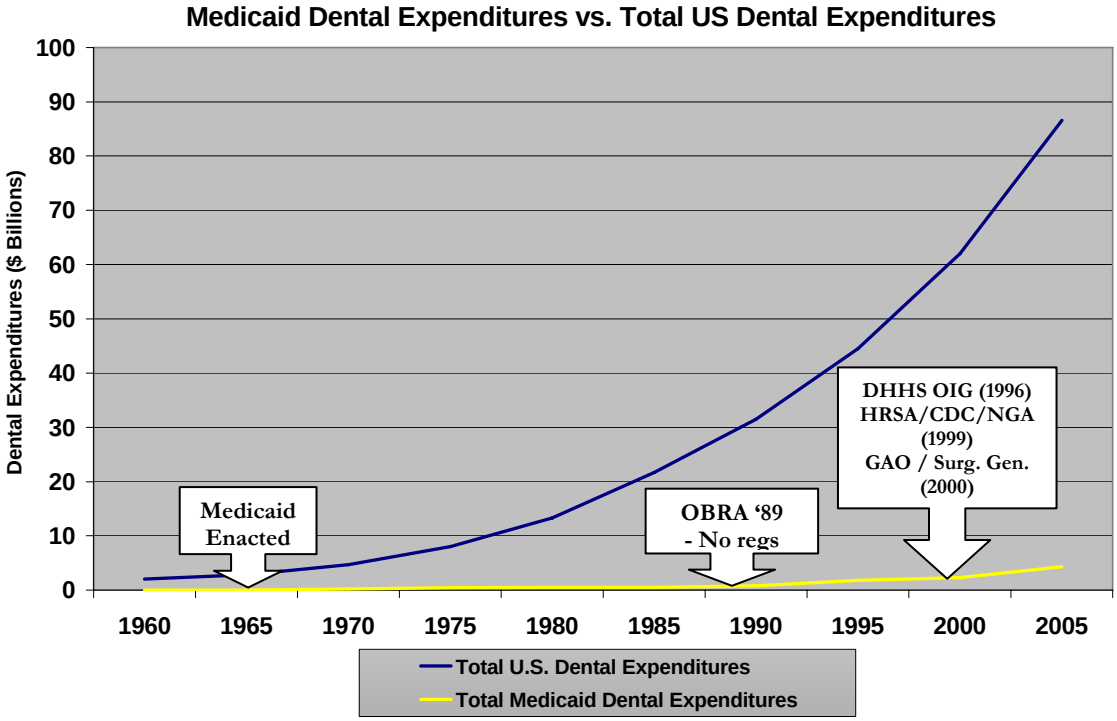
Financing, Budget and Reimbursement Decisions and their Relationship to Access to Dental Services for Children Enrolled in Medicaid

Access to dental services for children covered by Medicaid is a significant, chronic problem. Studies conducted by the U.S. Department of Health and Human Services[1] report that relatively few children covered by Medicaid receive recommended dental services and inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid. Reports issued by the U.S.

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

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

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



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

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

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

Problems with Common Approaches for Establishing Medicaid Reimbursement Rates[4]

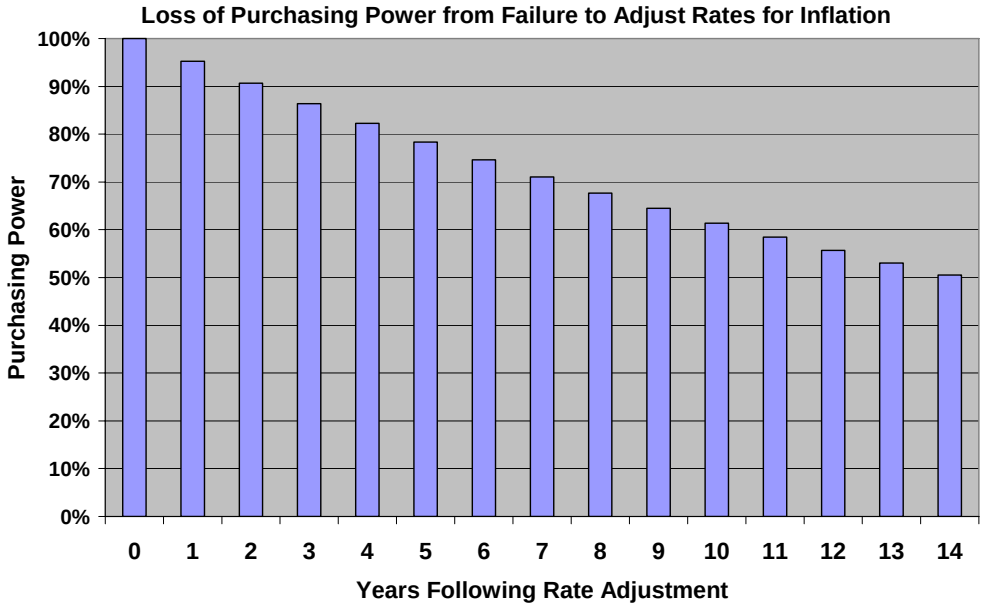
In many State Medicaid programs, administrators have based their reimbursement schedules on a fundamentally flawed application of the concept of "Usual, Customary and Reasonable" ("UCR") fees. In the commercial dental benefits sector, application of the UCR concept usually means that individual dentists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

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

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

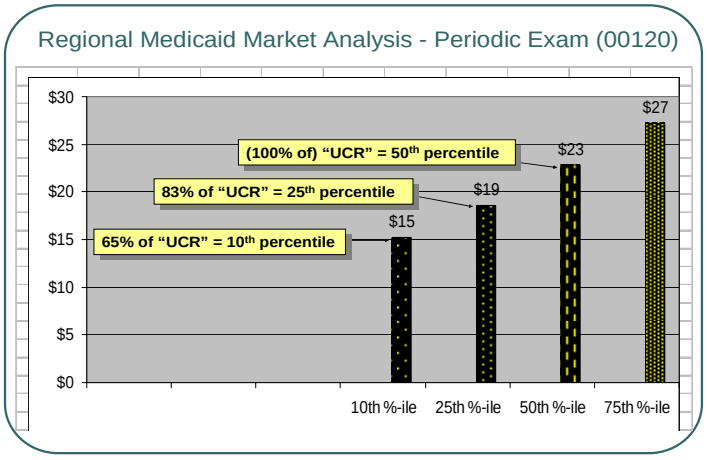
[4] Adapted from: Crall JJ, Schneider DA. Medicaid Reimbursement – Using Marketplace Principles to Increase Access to Dental Services. (Series of 10 regional policy briefs on this topic prepared for publication by the American Dental Association) March, 2004.

The chart below illustrates the loss of purchasing power over a 14-year period at an annual inflation rate in the cost of dental services of 5% (typical in recent times). Such intervals in providing adjustments for Medicaid reimbursement rates are not uncommon.



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

Comparisons of Medicaid "UCR" and Additional Discounts with Fee Percentiles



Using Percentile Analysis to Establish Marketplace-based Medicaid Reimbursement Rates

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

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

Establishing Market-based Medicaid Reimbursement Rates

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

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

The table below provides a comparison of Connecticut Medicaid payment rates for selected procedures and fees charged by dentists within the North East Region (CT, MA, ME, NH, RI, VT) and the State of Connecticut. Details of the data elements are summarized below.

CT Medicaid Payment Rates for Selected Procedures			Comparisons with Dentists' Claims for Insured Patients in the ADA New England (NE) Region and in the State of Connecticut			
CDT4 Procedure Code	Procedure Description	CT Medicaid Payment Rate	NE Region 50th Percentile	CT State 50th Percentile	CT State 75th Percentile	State Percentile Corresponding to CT Medicaid Payment Rate
Diagnostic						
D0120	Periodic Oral Exam	$18.08	$31.00	$37.00	$39.00	2nd
D0150	Comprehensive Oral Exam	$23.64	$50.00	$55.00	$70.00	3rd
D0210	Complete X-rays, with Bitewings	$45.00	$100.00	$109.00	$110.00	< 1st
D0272	Bitewing X-rays - 2 Films	$15.91	$33.00	$36.00	$38.00	7th
D0330	Panoramic X-ray Film	$35.00	$88.00	$95.00	$100.00	< 1st
Preventive						
D1120	Prophylaxis (cleaning)	$21.70	$48.00	$48.00	$50.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	$15.15	$27.00	$30.00	$32.00	4th
D1351	Dental Sealant	$17.75	$40.00	$40.00	$44.00	< 1st
Restorative						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	$37.64	$110.00	$115.00	$125.00	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	$46.20	$125.00	$132.00	$150.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	$328.48				**
D2930	Prefabricated Steel Crown, Primary Tooth	$85.01	$198.00	$222.00	$245.00	< 1st
Endodontics						
D3220	Removal of Tooth Pulp	$45.46	$114.00	$120.00	$150.00	< 1st
D3310	Anterior Endodontic Therapy	$200.01	$630.00	$550.00	$650.00	< 1st
Oral Surgery						
D7140	Extraction, Single Tooth	$33.12	$105.00	$108.00	$120.00	< 1st

The first two columns in the above table list procedure codes and descriptors for 15 procedures commonly used to assess Medicaid reimbursement rates for EPSDT services. The third column shows CT Medicaid payment rates in 2004 (which were largely unchanged since 1993 and have remained unchanged through 2007). The next two columns show the median or 50th percentile charges for these services by dentists in the six states in the New England region and in CT; while the second column from the right shows charges representing the 75th percentile of fees charged by dentists in CT. The far-right column shows the percentile equivalents for the CT Medicaid rates (i.e., the percent of dentists who charge the same or lower amounts than Medicaid paid). For example, the table indicates that for a periodic oral examination, the regional and CT 50th percentiles of dentists' charges were $31 and $37, respectively. The Connecticut Medicaid program paid $18.08 for that procedure, an amount that 2% of dentists CT would see as equal to or greater than their current charges (i.e., the 2nd percentile). Alternatively, 98% of dentists in CT would see the Medicaid payment rate as less than their usual charges. Of particular note, for 9 of the 15 selected procedures, the respective Connecticut Medicaid payment amounts are less than the usual charges reported for any dentist in CT. (i.e., less than the 1st percentile). From an economic perspective, these payment levels are substantially below the prevailing charges of the vast majority of CT dentists and would not be expected to provide adequate incentives for dentists to participate in Medicaid.

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

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

C. Program Financing and Payments

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

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

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

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