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on
"One Year Later: Medicaid's Response to Systemic Problems Revealed by the Death of Deamonte Driver"

before the
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Subcommittee on Domestic Policy

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Mr. Chairman and Members of the Subcommittee,

I appreciate the opportunity to testify today about the federal government's roles and responsibilities in ensuring that children in Medicaid have access to the dental care that is promised to them by federal law. My name is Dr. Burton Edelstein. I am a professor of dentistry and health policy at Columbia University and serve as Board Chair of the Children's Dental Health Project, an independent non-profit organization committed to improving children's access to oral health.

In my role as a professor, I have taught my students that public policymaking is the process through which government prioritizes and allocates resources to competing interests. We observe that dental care has fared very poorly in this competition; that Medicaid grossly underfunds dental care; that only one-in-three covered children obtains dental services in a year; and that adult dental needs are often ignored altogether. Yet we also recognize that CMS has many options at its disposal to improve this situation by exercising leadership, providing technical assistance, and holding states accountable for required performance. When we look at dental care in Medicaid, we note how little, how infrequent, and how inadequate are federal efforts to ensure that children have at least access to basic dental services that are essential for growth, health, and function. Most surprising to us is the paucity of attention paid to dental Medicaid in the year following the death of Deamonte Driver – not because the incident was so extreme (as it surely was) but because it so blatantly highlighted the importance of the dental Medicaid program for children.

As a consultant to the Department of Health and Human Services from 1998 to 2000, I came to know dental Medicaid through a formal joint HRSA-CMS dental access initiative. Under the two national Medicaid Directors who preceded Mr. Smith, the 10-year vacant CMS chief dental officer position was filled and situated with direct access to the Medicaid Director. A joint-agency Technical Advisory Group, or TAG, was formed. DHHS Regional Office capacity was bolstered. CMS and HRSA joined forces with the governors and state legislators to encourage and assist states. CMS funded demonstrations that showed cost saving *and* better health outcomes. The Medicaid guide was commissioned. State 416 performance reporting was strengthened. And states were required to report to CMS on their efforts and plans to further improve dental care for children in Medicaid.

As we now know, not one of these efforts was continued into the current Administration and only now – seven years later – are the TAG and state investigations being re-initiated.

As a participating clinician, I have come to personally experience the difficulties facing practitioners who seek to treat socially vulnerable children—difficulties that arise from a poisonous mix of low-payment and unnecessarily burdensome administration. As a result, parents still struggle to find care for their children. Yet my practice's experience with another governmental dental insurance program for children, the Department of Defense's Tricare Dental Program, shows that government *can* make dental programs work. Twice the proportion of military dependent children in the well-funded and

managed Tricare program obtain dental care as do children in Medicaid. The contrast between these two programs is both stark and telling about priorities and commitments.

So what could CMS do? I would suggest three things ranked from the least to most demanding:

1. *Exercise leadership:* CMS, and particularly the Director of the Office of Medicaid Services, could ensure that CMS staff, the staff in all regional offices, and state Medicaid directors know that dental care is not only federally required by EPSDT but it is an explicit priority. It could promote evidence-based early intervention that starts dental care before the start of disease by age two and put the "E" for Early back into EPSDT. With little expenditure of time and money, CMS could again partner with HRSA, CDC, ARQH, IHS, NIH WIC, Head Start, foundations and others to leverage each others' capacities, explore creative solutions, and prioritize dental care for children.
2. *Provide meaningful technical assistance:* CMS could provide intensive and extensive technical assistance to states – it could identify and promote best practices, issue guidance, release the complete Medicaid guide and TAG's findings, develop and disseminate model contracts, convene states to learn from one another, ensure a competent and ready cadre of regional officials, and develop novel Medicaid solutions that are now available under the HIFA and DRA provisions. When problems arise in dental program—as happened most recently in Georgia and Connecticut—CMS could offer its immediate assistance. As a

start, its current “Medicaid Dental Coverage” website could be dramatically expanded, promoted, and enhanced.

3. *Exercise oversight:* CMS has clearly demonstrated its willingness and capacity to act forcefully when it desires to do so, as evidenced for example by the August 17th stringent guidance to states on program expansions. Why CMS has not acted forcefully on the dental crisis is inexplicable unless one believes that even the death of a child cannot highlight the importance of basic dental care. A federal directive to states that compliance with reporting and service requirements is mandatory would bring attention and action where it is sorely needed and would capitalize on past efforts that are now so sadly stalled.

Taken together, the exercise of leadership, technical assistance, and oversight could bring dental care to the fore, honor Deamonte Driver’s life, and assist the millions of children in Medicaid who currently have so little access to needed care.