Opening Statement
Congressman Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee

"Evaluating Pediatric Dental Care under Medicaid"
Wednesday, May 2, 2007 – 2:00 P.M.
2154 Rayburn HOB

Good afternoon and welcome. The Domestic Policy Subcommittee of the Oversight and Government Reform Committee will come to order.

Today we are taking a closer look at the circumstances that led to the death of Deamonte Driver, a twelve year-old Medicaid eligible boy who died of a brain infection caused by untreated tooth decay. This hearing will focus on the adequacy of oversight of pediatric dental care in Medicaid.

In his 2000 report, *Oral Health in America*, U.S. Surgeon General David Satcher demonstrated that oral health is essential to general health. The mouth and its surrounding tissues provide protection against microbial infections and environmental germs and they are associated with detecting nutritional deficiencies and systemic diseases.

[SLIDE 1: CDHP slide] All oral diseases are progressive, cumulative, and consequential. Tooth decay often occurs in early childhood and is the most common childhood disease. **[SLIDE 2: CDHP slide]** 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. **[SLIDE 3: CDHP slide]** As the slide indicates, eighty percent of cavities occur in only twenty-five percent of children—predominantly low-income children. Low-income children suffer twice as much from tooth decay than do more affluent children.

[SLIDE 4:CDHP slide] Medicaid is the largest source of health insurance for low-income children, providing care for one out of every four children. Despite the coverage provided by Medicaid, it has been unable to fill the gap of providing dental care to poor children. In 1999, 26.12% of eligible children received any dental services—by 2005, that number had only risen to about 34%--<u>not many percentage points more than dental service utilization by uninsured children</u>. **[SLIDE 5:CDHP slide]**

On Monday the Center for Disease Control issued a new national study that found that tooth decay in baby teeth had increased

among U.S. toddlers and preschoolers aged 2-5 years old. The CDC study also found that 74% of young children with cavities were in need of dental repair.

In late February we witnessed the most tragic consequences of untreated oral disease. **[SLIDE 6: Washington Post article]** On February 25th, twelve-year-old Deamonte Driver died of a brain infection caused by untreated tooth decay. By the time Deamonte received any care for his tooth, the abscess had spread to his brain and after six weeks and two operations, Deamonte died. Filling a cavity, performing a root canal, or extracting the tooth might have saved Deamonte's life and yet the challenges in finding a dentist and ensuring care precluded that opportunity. Deamonte's death demonstrates both the importance of oral health to children's welfare as well as the sometimes fatal and often costly consequences of its inadequate access.

We will take a closer look at Medicaid in Deamonte's home state, Maryland. Using the Health Plan Employer Data and Information Set measures, they estimate that 45.8% of Medicaid eligible children aged 4-20 and enrolled for 320 days received dental care in CY 2005. Using the CMS Form 416 measure,

which is slightly different, the Maryland utilization rate for 2005 is 30.7%.

Oversight by government agencies is critical to ensuring that Medicaid serves the population as intended. But what is the quality of the data used in this oversight function? Consider this: one of the factors state regulators look at is the number of health care providers in the provider network. The managed care organizations providing the dental services report this number to the Maryland's Department of Health and Mental Hygiene. According to Maryland, between 2005 and 2006 the number of dentists serving the Medicaid population in Prince George's County increased from 162 to 360 providers. In Deamonte Driver's case, there were 24 dentists in all of Prince George's County, according to the directory published on the website of United Health Care.

In preparing for this hearing I directed my staff to do a spot check of dentists listed in United Health Care's provider network. Of the twenty-four dentists that they called, twenty-three of the numbers were either disconnected, incorrect, or belonged to a dentist who does not take Medicaid patients. The 24th dentist did accept Medicaid patients but only for oral surgery

and not general dentistry. Effectively, none of the twenty-four numbers listed would have been of any use to Deamonte.

The regulators, who use MCO-provided data, would have believed that the number of dentists that could have served Deamonte was 24, because that's what United Health Care would have told them. But the real number is "0." The case of Deamonte Driver raises a question we will consider in today's hearing: do the figures used for government oversight accurately reflect the accessibility and utilization of dental care?

We will also consider the role played by the Centers for Medicaid and State Operations or CMS. The Federal government provides half or more of Medicaid funding to every state. It is a function and responsibility of CMS to ensure that that money is being spent effectively to provide dental care to Medicaid eligible children.

CMS uses the Form 416 to ensure that children receive dental care as mandated by the Social Security Act. Although the Form 416 is the only oversight mechanism used by CMS to ensure compliance with the Act, not all states submit their Form 416s annually. And as one of our witnesses today will testify, even

when the Form 416s are submitted, the data may not be reliable or informative. The Form 416s do not tell us why utilization rates are low, how many children received adequate and appropriate care, how many of the children that received a screening received preventative or restorative care for that screening, how many dentists are providing the care for the children and whether or not only a handful of benevolent dentists are providing the care that should be spread across a broad network of providers. All the Form 416s tell us are how many children are enrolled in Medicaid, how many of them receive a screening, how many receive preventative care, and how many receive restorative care. Our hearing will afford us the opportunity to ask how can we confirm that dental care in Medicaid is adequate if the only information available to us is either incomplete, unreliable, or both?

We know even less about Medicaid managed care organizations. Managed care organizations do not complete Form 416s. They only report to the states. All of the data the MCOs report is created by the MCOs themselves. This is concerning since 47 states and the District of Columbia enroll some or all of their Medicaid populations in managed care. In 2004, managed care provided benefits for approximately 60% of Medicaid

beneficiaries nationwide. How do numbers reported by Medicaid managed care organizations and overseen by federal agencies reflect the reality of access to and availability of dental care? What do those statistics really mean? What do they tell us about children's dental care? Do we know enough to prevent another tragedy like that of Deamonte's?

Medicaid's inability to provide adequate dental care to children has been known since ***at least*** since 2000 when the U.S. Surgeon General published his report. At the time of the report's publication, Deamonte was only five years old. A year later, on January 18, 2001, when Deamonte was six years-old, the former Director of the Center for Medicaid and State Operations, issued a *Dear State Medicaid Director Letter* (DSMD). DSMD letters are often used by CMS to provide information, guidance, and direction regarding Medicaid policy. In that letter, the Director requested information on state efforts to ensure children's access to dental services under Medicaid.

The *January 18, 2001* Letter indicated that HCFA, presently known as CMS, would undertake intensive oversight of states whose dental utilization rates, as indicated on the HCFA-416 annual reports, were below 30 percent, including site visits by

Regional Office staff. States between 30 and 50 percent would be subject to somewhat less stringent review. The letter was written six years before Deamonte's tragic death—at a time when something could have been done to save him.

Significantly, Maryland was among the 15 worst performers. In 2005, the date of the most recent documentation, Maryland had just climbed out of the lowest category. That raises the question: would Deamonte's fate would have been different if CMS had subjected Maryland to a stringent review in 2001 as indicated necessary by the *January 18th Letter*? Was a critical opportunity lost to save a boy's life?

This is not a case of an unfortunate boy falling through the cracks, since the majority of Medicaid-eligible children do not receive dental care. Rather, it is a tragic consequence of a system that creates a captive population for managed care organizations and allows managed care organizations to report on themselves to government regulators. That is a system that puts profits before people.

A little boy died for lack of a dentist. A dental screening would have only cost the managed care organization in which he was enrolled about $15.

Taxpayers paid the managed care company about $4800 over the course of the last five years of Deamonte's young life to provide him with a dentist and routine screenings that he obviously never received. The managed care company's parent retained about $12.5 billion in net profits during that same period.