Testimony of Dennis G. Smith
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on
"Oversight of State Performance & Access to Dental Care for Medicaid Beneficiary Children"
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Good afternoon Chairman Kucinich, Representative Issa, and distinguished members of the Subcommittee. I am pleased to be here today to discuss oversight of state performance and access to dental care for children who are served by the Medicaid program. Medicaid is a shared partnership between the Federal Government and the States that will provide more than $300 billion in benefits this year. The Federal Government provides financial matching payments to the States while each State designs and runs its own program within the Federal structure and is responsible for administering its Medicaid program.

The Centers for Medicare & Medicaid Services (CMS) works with State Medicaid agencies to encourage quality care, adequate access, and appropriate use of Federal Medicaid resources.

Dental Coverage for Low-Income Children

Oral health care benefits are available for all 29 million children on Medicaid. States must provide dental screenings and diagnostic, preventive, and treatment services to children in order to receive federal matching funds. Preventive services may include oral exams, fluoride treatment, and sealants. Treatment services may include any medically necessary services including filling caries and performing extractions.

States also offer dental coverage through their State Children's Health Insurance Program (SCHIP) for nearly 6.6 million children. Currently, forty-nine (49) States and the District of

Columbia offer dental coverage through SCHIP. Many States provide coverage identical to that offered through Medicaid while others customize their benefits.

Services may be delivered on a fee-for-service basis or through Managed Care Organizations (MCOs). Nationally, 29.5 million individuals on Medicaid or 65 percent are served through MCOs.

Beneficiary Assistance and Protections

States typically help Medicaid populations to access services in a variety of ways ranging from providing general information on the eligibility determination process to the grievances and appeals process available to all Medicaid beneficiaries. All States have toll-free hotlines to assist individuals in identifying available providers in their communities. Many children, especially those with special needs, have case workers assigned to connect them with medical and social services they may need. Multiple contact points exist through providers, out-stationed eligibility workers, Federally Qualified Health Centers and other local community health clinics, schools, social service agencies, the foster care system, child protective services, and the State and local mental health systems.

All Medicaid applicants and recipients have the right under Section 1902(a)(3) of the Social Security Act and CMS regulations (at 42 CFR 431.200-250) to request a fair hearing when the State makes an adverse decision such as denial or termination of eligibility or denial of a service either because the service is not covered under the plan or because the service does not meet the criteria for coverage established by the State. An individual who exercises his appeal rights will receive, at a minimum, a fair hearing by an officer designated by the State.

Every State must give the individual a reasonable amount of time, not more than 90 days, to request an appeal. To ensure timely actions, the State has 90 days from the date an appeal is requested to render a decision. A recipient can continue to receive the contested services while appealing but generally file the appeal within 10 days from the date the notice is sent by the State. The notice at each stage of the appeal process informs the recipient of the decision, the

reasoning used and any further appeal rights, including the extent to which the individual may appeal to the State courts.

CMS also developed several regulations to protect consumers receiving care through a managed care delivery system when it became evident that managed care held promise for cost, efficiency and quality in Medicaid. Under these arrangements, consumers also have a right to an appeal if services are denied, limited, or not provided in a timely manner. They also have the right to file grievances about any matter such as concerns about quality of care, provider behavior, or failure to respect the enrollee's rights. Medicaid law and regulations provide for a variety of sanctions against an MCO for failure to meet requirements.

States are required to ensure that MCOs are following Medicaid requirements. CMS provides oversight and monitoring of these activities by reviewing External Quality Review reports which are required for every State that has a managed care delivery system. CMS has developed tools and conducted conferences to help States with their External Quality Review functions. CMS also has regularly scheduled calls with state Technical Advisory Groups made up of State Medicaid Managed Care and Quality Improvement Directors to implement the recommendations.

States have engaged in many activities to provide access to quality dental services for children. For example:

- Alabama established a Governor's Dental Task Force for improvement, raised dental fees and provided case management services to assist patients in keeping appointments.
- Michigan contracted with a commercial company for the provision and administration of dental benefits in certain rural counties. This provided Medicaid beneficiaries with benefits similar to commercial coverage.
- Virginia contracted with a single dental insurance company to administer its programs for both Medicaid and SCHIP. This change provided many administrative benefits, streamlined the process and increased the number of dentists available to provide services.

Maryland Efforts

Over 370,000 children in Maryland receive care through a comprehensive managed care delivery system. In 2004 the State passed legislation requiring dentists who participate in their managed care plan to notify the MCOs when enrolled children are in need of dental therapeutic/restorative treatment that the dentist was unable to provide. Maryland also imposed incentive / disincentive payment arrangements on MCOs based on their provision of dental services to children ages 4 – 20.

Also, MCOs are required to provide families with a list of participating dentists who provide the needed therapeutic/restorative treatment, and assist the family, if necessary, in arranging an appointment for the needed care if necessary. An MCO's compliance with the requirements is monitored on an ongoing basis by the State.

Maryland also has a consumer hot line that records complaints from MCO members and is used to monitor services and intervene as necessary. A provider hotline is also in place that records complaints regarding Medicaid operations including reimbursement rates.

The State, through its managed care providers, implements outreach and consumer protection activities including:

- Automated calls, letters, and postcards to members reminding them to seek healthcare services at appropriate time intervals.
- Follow-up with beneficiaries that have not followed through on appointments by coordinating with the county health departments for outreach.
- A dental outreach effort, entitled "Healthy Smiles", in which incentives are provided to members who seek primary dental care.

In 1998 Maryland assembled an Oral Health Advisory Committee, which has developed an Oral Health Action Plan. Maryland also increased their provider rates for physicians, including dentists, by nearly $200 million after receiving waiver approval from CMS. In addition, the Maryland General Assembly passed a legislative initiative that appropriated $1 million per year of additional funding for the Medicaid dental program, beginning in 2009. The State reports that

after implementation there was a corresponding increase in the number of providers and in recipients being served.

Also, the Maryland legislature has instituted a loan repayment program for dental students, which requires, among other things, that they provide services to Medicaid patients. Through this loan repayment program, Maryland expects to add 15 new dentists per year to the rolls of Medicaid providers. Maryland also has 78 health care delivery sites operated by Federally-funded community health centers.

As a result of the innovative approaches taken by Maryland, the State has realized improvement in quality and access as demonstrated by increases in their Health Plan Employer Data and Information Set (HEDIS) performance measures, which are used to measure quality. Between 2001 and 2004, the State of Maryland used HEDIS to measure children's access to primary care physicians, adult access to preventive and ambulatory health services, well-child visits, prenatal and postpartum care, comprehensive diabetes care, and use of appropriate medications for asthma. In all categories, except the use of appropriate medications for asthma, Maryland exceeded the Medicaid average. In fact from 2001-2004, Maryland rates consistently trended upwards, at a rate of change between 3 percent and 11 percent.

In the case of dental services, 2005 data indicate that 33 percent of children received dental services, in contrast to 19 percent in 1998. This rate is the same as the national average for Medicaid dental visits according to 2005 CMS data.

Other Sources of Dental Coverage:

Medicaid is just one source of dental coverage for low-income families and children. Many low-income children and their families can receive dental services through public health programs, community health centers, or dental schools that provide free or reduced-fee services. The Centers for Disease Control and Prevention leads federal efforts in promoting oral health through public health interventions and has helped states strengthen their oral health programs, has reached people hardest hit by oral diseases, and has expanded the use of measures proven effective in preventing oral diseases. In addition, the Health Resources and Services Administration (HRSA) has an Oral Health Disparities Collaborative which is working to

provide greater access to oral care for children, and the Indian Health Service provides dental care to eligible American Indians and Alaska Natives.

HRSA's Maternal and Child Health Bureau partners with agencies for families and children and the Head Start Program to provide greater access to dental care for children enrolled in Head Start. HRSA also funds pediatric dental training residencies. For pediatric doctor residents, HRSA offers an "all health" curriculum that integrates oral health into overall health care.

Community Health Centers including, Federally Qualified Health Centers, including HRSA's funded health centers, play a critical role in providing dental services and transportation. These centers provide services regardless of an individual's ability to pay, even if the patient has no health insurance. The percentage of health centers providing preventive dental services onsite has increased steadily since the beginning of the President's initiative in 2001. At the end of calendar year 2005, there were over 950 federally-funded health centers with more than 3,745 primary care delivery sites located in urban and rural underserved areas. Overall, 84 percent of health centers provide preventive dental services, an increase of over 30 percent since 2001. In addition, the number of health center dental staff has increased by 70 percent over the 2001 total.

Challenges

In an April 2000 Urban Institute study, *Gaps in Prevention and Treatment: Dental Care for Low-Income Children*, researchers identified "[t]hree factors that may impede utilization of dental services by children: lack of knowledge about or low priority given to meeting recommended dental care standards, lack of access to providers, and a lack of means to pay for care." This report was based on the 1997 National Survey of America's Families and included information about children with private health insurance, public health insurance, as well as those who were uninsured.

Interestingly, the use of dental care between privately and publicly insured children was quite similar but the barriers they faced differed. The study found that 17 percent of uninsured children had unmet need, but only 7 percent of publicly insured children and 5.7 percent of privately insured children had an unmet need. The percentage of children with no dental care

visits for publicly insured children and privately insured children was 23.8 percent and 23 percent respectively, compared to 35 percent for uninsured children.

Medicaid benefits for dental care for children are more comprehensive than benefits typically offered to children who are privately insured. Underinsurance and variations in coverage are likely the primary barriers for privately insured children, while the primary barrier for children with Medicaid coverage is likely to be access to care.

Historically, low dental provider participation has been a challenge in a number of State Medicaid programs. Low provider enrollment is generally attributed to low Medicaid reimbursement rates in the States; beneficiary non-compliance/missed appointments; and an overall lack of available dentists in certain rural or urban areas.

In one study conducted for the Minnesota Department of Human Services between November 2000 and February 2001, *Perspectives of Dentists and Enrollees on Dental Care Under Minnesota Health Care Programs*, the State surveyed both providers and enrollees to gain better insight into the oral health care challenges faced in public programs. From the provider perspective, low fees and broken appointments were the most commonly identified problems in serving individuals enrolled in the Minnesota Health Care programs, which includes Medicaid and other State programs. Overall, 93 percent of dentists reported that low reimbursement fees were a very significant problem. Less than 1 percent of dentists reported they were receiving fees that they considered acceptable. The second most common reason for low provider participation was broken or cancelled appointments, with 82 percent of dentists reporting this as a significant problem.

There are also important lessons to be learned from the enrollee perspective. According to the report, the survey of more than 12,000 enrollees showed that only 50 percent of parents/guardians (reporting on behalf of a child) did not accept the need for preventive dental care. However, for those expressing a need for dental care, 88 percent of children were able to receive it. Enrollees reported that about one-third experienced difficulty finding a dentist, of

which 17 percent described the problem as “big” and 14 percent described as “small.” Access problems for children differed by region.

In light of these challenges, CMS continues to work with key partners to ensure that patients have access to dental care. Improvements to access, quality and reporting will continue as states implement evidence-based performance measurement supported by health information technology (HIT).

CMS Oversight and Access to State Dental Benefits

When considering efforts to ensure children’s access to dental health in the Medicaid program, again it is critical to remember that Medicaid is a joint Federal-State effort, with States having the primary responsibility for administration of their programs within Federal guidelines. The Medicaid program has a number of checks and balances that facilitate identification and resolution of problems in addition to those previously mentioned for beneficiary protection. The States have the responsibility to work directly with their providers and beneficiaries, and CMS monitors States to ensure that they are in compliance with their plans and Federal law.

CMS works with States to prevent and correct systemic issues as they become known through internal and external review processes. For example, CMS worked to implement recommendations from the 2001 Government Accountability Office Review on Children’s Access to Health Screening Services which centered around Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) reporting and providing a mechanism for sharing information among States on successful State plans and provider practices for reaching children in Medicaid. Through our work with States, the participation ratio in all EPSDT services increased by 32 percent since 1999 and the percentage of children receiving dental services increased by 23 percentduring the same time period. In Fiscal Year 2008 it is estimated that Medicaid will spend in excess of $700 million on EPSDT screenings.

In addition to oversight, CMS also works to improve access by aligning payment structures. For example, to further address the challenges to enrolling providers in Medicaid due to fee and reimbursement issues, CMS approves State Plan Amendments (SPAs) that call for payment for

dental services at the level of charges, as long as the charges are applied equally to all payers. Section 1902(a) (30) (A) of the Social Security Act requires that Medicaid payments be consistent with efficiency, economy and quality of care. Normally, CMS does not recognize payment up to charges as being economic and efficient because charges are set by the provider. However, in the case of dental access, payment up to charges is an important tool available to State Medicaid agencies to encourage the availability of quality dental services. CMS also permits States to pay up to the Average Commercial Rate (ACR) for dentists.

CMS' Medicaid Quality Initiatives

The CMS quality initiatives include moving States towards quality assessment of Medicaid and SCHIP services through evidenced-based performance measurement and dissemination of best practices.

CMS is currently exploring many options to improve data collection and monitoring to inform quality decisions. One important source of data that already exists is the annual EPSDT report, CMS Form-416, which provides basic information on states' compliance with EPSDT requirements. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receive dental services. States must submit a Form 416 annually. CMS works with States on an ongoing basis to improve the quality of the data provided on the Form 416 to better assess the types of services provided (e.g., the percentage of Medicaid-eligible beneficiaries receiving preventive dental and treatment services).

States have historically had problems capturing managed care data with Form 416. CMS has recently purchased the National Committee for Quality Assurance (NCQA) Quality Compass to determine if it might be a better source of data for Medicaid MCOs. While the Quality Compass is a very reliable and valuable source of audited data, not all health plans report to the database. It cannot currently be used for national analyses.

Like many traditional reporting mechanisms, CMS believes that Form 416 has limitations in an era of electronic health records and quality improvement supported by health information

technology. As a result, CMS has launched a "Value-Driven Health Care" initiative in support of the Secretary of HHS' priorities to ensure interoperable health information technology, transparency in quality information, transparency in price information, and value-based purchasing. States are requested to move rapidly into using national performance measures and interoperable systems that will help improve reporting in all areas including EPSDT. CMS and its sister agency, the Agency for Healthcare Research and Quality (AHRQ), will provide support to states in these efforts.

To increase education of preventive services available through Medicaid, CMS partnered with the American Academy of Pediatric Dentistry (AAPD) in 2004 to produce a *Guide to Dental Care* for Medicaid. Information provided through its publications, websites and community partnerships, has helped children get the preventive and dental care they need.

CMS has reached out to low-income parents to inform them of the importance of screening and health maintenance through a series of brochures entitled "Healthy Start, Grow Smart." The brochures cover a number of areas related to health, growth and development including dental education to prevent tooth decay and the need to visit a dentist. We believe that education about early use of dental care is important to participation and compliance. CMS has distributed over 51 million Healthy Start brochures to low-income children and families nationwide.

We certainly need our external partners as well. For example, the ADA has an online guide to *State Innovations to Improve Dental Access for Low-Income Children: A Compendium.* This compendium identifies and summarizes successful state interventions related to Medicaid/SCHIP oral health care for children.

More recently, CMS began the process of integrating EPSDT services into an overall CMS Medicaid Quality Strategy to move toward a more contemporary and comprehensive approach to achieve the goal of delivering the right care, for everyone, every time.

- Under this initiative, CMS continues a dialogue with the American Dental Association that began in late 2006. Discussions include exploring the development of quality measures related to value-based purchasing in dentistry.

- CMS and AHRQ meet regularly with State Medicaid Medical Directors to discuss promising practices and devoted an entire session to EPSDT services last spring.
- CMS established a Medicaid/SCHIP Quality page on its Web site to share promising practices in all areas of Medicaid. Targeted topics related to EPSDT include access, asthma, dental, diabetes, health disparities, health information technology and performance measurement. CMS is in the process of populating this page, which can be found at can be found at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/;
- In late 2006 CMS published The Guide to Quality Measures: A Compendium, which contains nationally recognized, tested, and vetted quality measures to support States' programmatic needs in many areas of quality improvement. The site can be found at www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/pmfinalaugust06.pdf.

CMS Regional Offices (ROs) are involved in numerous activities with States regarding EPSDT and oral health issues. A few examples of RO activity include:

- Monitoring submittal of CMS Form- 416 reports and performing EPSDT oversight reviews by interviewing State staff, providers and community partners;
- Reviewing and providing input on State plan amendments and waiver applications for programs impacting children and pregnant women;
- Developing a curriculum for, and providing a one-day EPSDT 101 training for States, and;
- Providing technical assistance to regional Head Start programs.

Conclusion

CMS has made significant progress in overseeing and promoting quality pediatric dental benefits in the Medicaid program. We know our work is not over and we must remain vigilant and proactive. Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.