Testimony of

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For the

Domestic Policy Subcommittee
Committee on Oversight and Government Reform

"Evaluating Pediatric Dental Care under Medicaid"

2154 Rayburn HOB – 2:00 P. M.

Wednesday, May 2, 2007

Introduction

Thank you Chairman Kucinich, Representative Issa, and other distinguished members of the Committee for the opportunity to testify today about the important role of pediatric dental care for Medicaid-eligible children. I am Dr. Allen Finkelstein, and I am Chief Dental Officer of AmeriChoice, which is UnitedHealth Group's business unit exclusively committed to serving beneficiaries of Medicaid and the State Children's Health Insurance Program (SCHIP).

I am also here today as a practicing dentist of more than 35 years. Like any health care professional, my role is to take care of people, and I feel a profound sense of loss at the untimely death of Deamonte Driver in Maryland. His death was a tragedy that saddens all of us.

Out of this tragedy, all of us owe it to our children and our communities to take a closer look at how children with Medicaid receive dental care, in Maryland and across the country. At AmeriChoice, we remain fully committed to working with parents, communities and the government to ensure that timely dental care is not just *available* to our most vulnerable children, but that it also is *delivered* to them.

UnitedHealth Group provides a diverse and comprehensive array of services to 70 million Americans. Since 1989, AmeriChoice has been dedicated to helping Medicaid-eligible children and their families obtain the preventive and acute health care services they need – including dental care; treatment for chronic conditions; and attention to unique and often complex health and well-being issues. We have earned a reputation as an innovative developer of health care solutions in many of the states where we operate.

I have devoted my whole career to preventive dental medicine, beginning in 1969 as a U.S. Army Captain. When I was at Fort Bragg in North Carolina, there were so many dental emergencies in Vietnam that the Army asked me to develop a stateside program to increase preventive care and decrease dental emergencies among troops *en route* to Vietnam. Nearly 40 years later, it is unfortunate to be here today speaking to you about similar, preventable dental problems. However, in the Army, my patients showed up for their appointments – with 100 percent attendance. By contrast, the Medicaid patients we are discussing today often face challenges that make it difficult to take advantage of the full spectrum of dental care benefits available to them.

Concurrent with my work at AmeriChoice, I continue to see patients on the weekends in my Great Neck, New York practice. My comments today are informed by a few simple, but important beliefs, which I share with AmeriChoice and which are the chief reasons I work for the Company:

- Dental care is critical to overall well-being and should be on a par with other aspects of health.
- A person's health must be viewed holistically, and health care must be approached in an integrated way.
- Patients should always come first and be cared for personally as individuals.
- Medicaid beneficiaries face challenges in accessing adequate health care. It takes flexibility and a willingness to try new and innovative approaches to make health care work better for them and for the providers who treat them.
- And, finally, to understand your patients, you need to stay in close touch. I am grateful that AmeriChoice recognizes the value in this connection to members by enabling me to continue to see patients and work one-on-one with providers and communities across the country.

Today, AmeriChoice serves more than 1.4 million members in health plans through Medicaid and SCHIPs in 13 states. Our participation in the Medicaid program is fundamental to our parent Company's core mission: to support the health and well-being of individuals, families, and communities. As Chief Dental Officer at AmeriChoice, I personally review more than 4,000 dental cases each month to ensure the highest and most equitable standard of care for our members.

With all of this in mind, I believe we can offer important perspectives based on our experience. While this hearing has been convened ultimately as a result of a tragedy that occurred in the State of Maryland, we appreciate the opportunity to discuss the issues related to providing pediatric dental care to Medicaid-eligible children nationwide, and to consider potential solutions to bridge gaps. We would like to commend Chairman Kucinich and members of the Subcommittee for holding this hearing and also Chairman Dingell and other Members for proposing thoughtful legislation to address the issues.

Driving Increased Utilization of Available Services, Fostering Holistic Care

There are two significant issues that affect the provision of dental care to Medicaid beneficiaries and the uninsured – access and utilization. Much of the recent public debate has centered on access to providers. We are focusing our testimony today on utilization, which has received far less attention. A child may have access to a network of willing dentists, but nothing meaningful happens until the child sits in the dentist's chair.

From our experience, the most pressing challenges in increasing utilization is educating families about the importance of dental care, engaging providers and parents in a proactive and holistic approach to children's health, and encouraging the use of the wide range of dental services and benefits available. Driving increased utilization by the most vulnerable families will require a strong shared commitment and collaboration from all involved, namely government agencies, schools, community organizations, parents, insurance companies and the health care community. We all need to be in this together.

I will focus my remarks today on four key areas:

1. The importance of preventive dental care to children's general health

2. Barriers to delivering dental care

3. The AmeriChoice approach

4. Potential broad solutions

The Importance of Preventive Dental Care in Children

We have all seen how poor dental health can lead to much greater physical health issues. Addressing dental problems early in children's lives can make a meaningful difference in their growth, development, and future adult health.

Tooth decay is America's most prevalent chronic childhood disease, more widespread than asthma and diabetes. Of the 4 million children born each year, more than a half of them will have cavities by the time they reach second grade, according to the Children's Dental Health Project. For lower income populations, the situation is more severe. In the 2000 "Oral Health in America Report," U.S. Surgeon General David Satcher called dental and oral disease a "silent epidemic," disproportionately affecting poor children. Children in poverty are more likely to experience dental decay and cavities, and those children without dental insurance are three times more likely to have dental needs than children with either public or private insurance. An estimated 20 million children in the United States do not have dental insurance.

This is particularly unfortunate, because dental disease is largely preventable and treatable. Preventive treatment is cost effective and can ensure against more expensive ailments and unnecessary disease. Proper care and education must start early, and reinforcement must come from all areas of a child's life, including dentists, medical doctors, parents, and schools. Since pediatricians and other child health professionals are far more likely than dentists to encounter parents and children with Medicaid, it is essential that doctors reinforce, educate and give priority to dental care and oral hygiene. Care of the teeth needs to be linked with care of the rest of the body.

Whenever I must extract a diseased tooth from a child, I count it as a failure of the system. I've dedicated my career to educating parents, practitioners, and insurers on these preventable problems.

Barriers to Delivering Dental Care to Children with Medicaid

There are many barriers contributing to this silent epidemic, including a lack of adequate education and understanding about the detrimental effects of poor oral health. More needs to be done to educate the public and those in the medical field to put an end to the epidemic.

Socio-economic factors: In many cases, families with lower incomes have needs that compete with and take priority over adequate dental care. Dental hygiene often takes a back seat to basic daily survival needs such as food, shelter and child care. These issues often are compounded by language and cultural barriers and the complexities inherent in administering a multi-faceted program such as Medicaid.

Dental care not prioritized: Common misconceptions and out-of-date beliefs about dental health are rampant. Many parents and community leaders do not understand the importance of dental health and its connection to more serious health issues. For instance, many parents think taking care of baby teeth is not integral to overall dental hygiene, and as a result, the dental health of a toddler growing into a child is compromised. Once again, this is where pediatricians, insurers, school systems and government agencies can be of enormous assistance.

If parents are not educated about the importance of oral health, or if they have more pressing life needs, dental services will not make it to the top of their list.

Other important factors also contribute to low utilization and dental care delivery problems, including difficulty in communicating with members and the declining number of dentists generally.

Communication hurdles: Health plans report challenges in communications with Medicaid beneficiaries. Because many people on Medicaid have transient living situations and frequently lack telephone service, regular communication with beneficiaries is impeded. At AmeriChoice, we have experienced a high rate of returned mail in mailings to Medicaid beneficiaries, for example.

Another significant issue health plans experience is lack of understanding about the reasons children or whole families are dropped from state Medicaid rolls. As the health insurer, we receive a data feed from the state that tells us who has dropped off of Medicaid, but we rarely know why. It could be the result of a rise in income that leaves a family no longer eligible for Medicaid, or it could be that a homeless family has moved from one shelter to another and did not receive the paperwork for renewing eligibility. Even if the paperwork arrives safely, more basic concerns may take precedence over navigating the administrative process. Current Medicaid rules prevent us from contacting a family once they are dropped from Medicaid and from our program.

Dental Provider Participation: Integral to this discussion are the issues related to the providers themselves.

The United States is experiencing a shortage of dentists and people entering the dental field, and some dental schools have been closing. Twenty percent of current dentists are expected to retire in the next ten years, and there are an insufficient number of replacements in the pipeline. Moreover, the number of people electing to go into pediatric dentistry as a specialty has diminished. It would take a significant and immediate increase in dental school enrollments to reverse the overall trend.

Support and incentives for dental providers to treat children with lower incomes are also insufficient. Many dentists find it too difficult to treat children six and younger, and report a high percentage of missed appointments with Medicaid beneficiaries.

To serve the needs of Medicaid beneficiaries effectively, we must also address the needs of the providers who care for them.

The AmeriChoice Approach

AmeriChoice is a leader in providing health and dental care benefits to the nation's most vulnerable populations because we offer a holistic approach to health, involving members, families, providers and government and community organizations to ensure continuous and effective care.

Medicaid is broad and deep in what it provides beneficiaries, although there are some variations from state to state. Our package for Medicaid beneficiaries often goes beyond the standard Medicaid mandates. We base our benefits on the philosophy of increasing utilization of preventive services. Members are less likely to need expensive and sometimes traumatic specialty care if they maintain the best health possible. To that end, we provide case management, care coordination and customer service.

For example, AmeriChoice offers to its Medicaid members:

- A member services call center, staffed around the clock, for referral services, assistance in making medical and dental appointments, and general information on where to find medical care. The toll-free number for the call center is printed on the back of the membership card issued to every member.
- There is also a second call center specifically dedicated to dental services, which is staffed from 8 a.m. to 8 p.m., Monday through Friday.
- For chronically-ill members, we assign a professional case manager, either a registered nurse or social worker, to assist members in coordinating the best care possible.
- Coordination of transportation to and from medically necessary appointments, including dental appointments.
- Health education prevention materials including quarterly newsletters and targeted mailings to keep members informed of important and timely health matters.

Education and awareness building is also critical to implementing our integrated approach to care. We are supporting education and cross-training programs for pediatricians and dentists about the clinical aspects of dentistry and the socioeconomic issues facing Medicaid beneficiaries. For example, we are educating pediatricians to speak knowledgeably to a mother about the importance of not leaving a child unattended with a bottle of milk or sugary drink, as it causes enamel erosion and potential tooth decay.

AmeriChoice and Innovation

One of our most significant achievements in the area of dental care has been the creation of a strong dental provider network. Noteworthy is the State of Maryland, where we have more than 100,000 Medicaid members. The State requires a minimum of one network dentist for every 2,000 members in a service area. In Maryland's Prince George's County, we have a much better ratio than that, at 1 dentist for every 250 members.

No matter how robust our network is, it is only effective if the services are used. We have increased utilization by our hardest-to-reach members by creating innovative programs that address unique and specific needs. We firmly believe we can increase visits to the dentist if we join forces with communities, state governments and providers.

In Maryland, there have been dramatic improvements in utilization of dental services by Medicaid beneficiaries. In 1997, before health plans began administering Medicaid programs, dental utilization was less than 20 percent. In 2005, it reached more than 45 percent. While that is an improvement, it is not good enough, and we believe legislation introduced by Energy and Commerce Committee Chairman Dingell is a step in the right direction.

At AmeriChoice, we are pursuing several avenues to educate members about the importance of dental care and to encourage them to obtain it:

- The Happy Smiles program gives members an incentive to encourage them to obtain preventive dental care. Parents who take their children under age 21 for preventive care are given a $10 retailer gift card for every dentist visit.
- We partner regularly with providers, county health departments and Head Start programs to conduct dental screenings of children, provide toothbrushes, and provide basic oral health education, regardless of their insurance coverage. The most recent event, held at Highland Park Elementary Head Start in Landover, Maryland, was attended by 101 children.
- We produce a quarterly bilingual enrollee bulletin which contains periodic articles on dental topics such as "Fluoride for Healthy Teeth" and "Getting Kids to Brush their Teeth"

Effective Partnerships are the Key to Delivering Results

I have spoken of the need for collaboration among all parties involved, including government agencies, schools, community organizations, parents, insurers and the health care community. This collaboration is not just a hypothetical concept. It leads to real benefits in the lives of real people.

In 2006, we launched an ambitious program in Rhode Island to get to the heart of the matter. It is an innovative approach – prevention oriented, focused on early intervention, and engaging both medical and dental providers. In close collaboration with the state, we built a network around caring for children ages 6 and below. We currently have the more than 32,000 Medicaid eligible children in Rhode Island enrolled in the program.

The *RIte Smiles* program stresses preventive care and education, launching these kids on what we hope will be a lifetime of good oral hygiene. All care is provided at no cost to the families of children with Medicaid.

We have eliminated barriers wherever possible, so providers can focus on dentistry. We do only retrospective reviews of claims – no preauthorization is required for most procedures – and we have simplified the credentialing process for providers. We assign case management for special needs and high risk children, and providers are reimbursed for case management when the outcomes are good.

Based on the success of the program, the State is now considering a bill to expand the program to all children up to age 11. It is an excellent example of a public-private partnership providing real value to some of Rhode Island's most vulnerable people, and we are eager to build on what we have learned and start to replicate the program in other states.

I have talked about integrating dental and medical care. A family with Medicaid is much more likely to take a child to see a physician than to see a dentist. Thus, in collaboration with the medical school at Brown University in Providence, we are teaching early detection and rudimentary dental care skills to pediatric medical school students. The students participate in a hands-on course on how to provide a fluoride varnish, which serves as a partial immunization against decay. It is a three-minute procedure, and we compensate providers for doing it. The pediatric students also learn how to detect serious dental problems, so they can make a referral to a dentist in a timely way.

We have other pilot programs that demonstrate the power of collaboration.

- In Paterson, NJ, we are working closely with a school district that has mandated all children visit a dentist prior to returning to school each fall. Enough of these children have Medicaid to drive a good volume of local demand, so we have been able to recruit a robust network of dentists. We also participate in health fairs with pediatricians in the area; and in some cases we work with a mobile dental van that can bring basic care to any location.
- At the Arizona School of Dentistry, we helped fund the establishment of a center for treating special needs children and a mobile treatment program. For AmeriChoice, it is money well spent, because if we can treat patients at home or in a dental facility, they are more likely to avoid a traumatic and expensive emergency room visit.
- In Neptune, NJ, we worked with the University of Medicine and Dentistry of New Jersey to establish a hospital-based dental center, where dental students provide screenings and care to Medicaid-eligible children from 7 p.m. to 10 p.m. every Monday.
- The UnitedHealthcare Children's Foundation (UHCCF) provides financial assistance to help children with medical needs that are not covered by their family's health insurance. UHCCF grants cover the family's share of medical expenses for services which include orthodontia and dental treatments. Since its inception in 1999, the Foundation has provided more than 375 families with nearly $1 million in financial assistance.

These programs work. They provide better outcomes for patients, and in many cases save money in the long run for state Medicaid programs. All that is needed is a willingness to think differently about care, and for the many relevant stakeholders to work in partnership.

Potential Broad Solutions: The Need for a Shared Commitment, Action

Innovative and collaborative partnerships are essential to providing the best options and care for our members. As a starting point, we envision pilot programs where insurers have opportunities to work with government agencies, the community, municipalities, school systems, members and health providers.

- Schools are a valuable mechanism for first dental screenings. As we have experienced in our New Jersey program, initial basic dental care can be introduced through coordinated "dental hygiene days" where dentists examine and provide basic dental care to students at the school.
- Mobile vans can visit large and small communities in remote locations to provide dental care such as exams, x-rays and cleanings. We are exploring rolling out a similar program in Maryland.
- If we want to increase the commitment from dentists to treat Medicaid beneficiaries and, to increase utilization of patients, we need to be able to provide incentives. For instance, as a health insurer, Federal law prohibits us from using Medicaid funds to compensate dentists for missed appointments. Providers have reported "no-shows" as a significant deterrent for accepting Medicaid patients.
- Dental care can be emphasized and elevated as a public health issue through improved partnerships with schools, community centers, private sector, government agencies and houses of worship. Treatment sites can be hosted, full-time or part-time, in alternate venues to provide care and help educate people about the importance of dental care to overall physical health and lifelong well-being.

Policies and Legislation

Medicaid does work. It has been extremely valuable to children and their families across the country. However, Congress can play a pivotal role in improving Medicaid, making it more accessible to providers and easier for the most vulnerable people in our country to use. Currently, states are required to inform Medicaid beneficiaries of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program which provides dentist referrals, regular screenings, and general dental care maintenance and restoration. All 25 million Medicaid beneficiaries under the age of 21 are eligible for EPSDT. However, less than one in four children with Medicaid receive these services. We believe Medicaid could help us as the health plan administrators to increase utilization, so that children and their families receive adequate preventive care for a lifetime of healthy teeth and gums.

We suggest three areas where public policy changes could make the most impact:

- Elimination of separate licensing requirements for Medicaid dentists. Currently in some states, a dentist must obtain a separate Medicaid ID number to participate in a Medicaid HMO.
- Institution of dental screening requirements prior to the beginning of each school year, as is current practice with child immunizations and well-child checkups. Sixty years ago when I was about to enter kindergarten, my parents were required to bring me in for a dental exam. But today, 25 percent of poor children start kindergarten without ever having seen a dentist, and in most cases there is no requirement that they do so.
- Training and education programs to help prepare minority high school and college students for a career in dentistry and grants to train pediatricians and dentists in the field of pediatric dentistry.

In closing, we applaud the efforts of Congress to approach dental care for children more holistically and to consider solutions that help bridge gaps in care. We are committed to working with you, the Senate, providers, and all the participants to address current and future challenges. We are determined to do all we can individually and collaboratively to not only fulfill the promise of Medicaid for children but to help improve on the program.

Thank you, Mr. Chairman for the opportunity to speak today on behalf of AmeriChoice and on behalf of my patients.

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