STATEMENT FOR THE RECORD

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Before the

Domestic Policy Subcommittee
Oversight and Government Reform
"Necessary Reforms to Pediatric Dental Care under Medicaid"
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2154 Rayburn HOB
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Executive Summary

The ADA applauds the subcommittee for its request for recommendations to increase the number of dentists providing services to children enrolled in Medicaid and we are pleased to offer our suggestions. It is important to note that over 90 percent of all practicing dentists are in the private sector. Safety net facilities that target underserved populations are, of course, very important but they employ relatively few dentists. For example, in fiscal year 2007, Health Centers receiving Section 330 funding employed about 2,107 (FTE) dentists. Even after significant growth in Health Centers in the past several years, that is still less than 2 percent of the total of 177,686 active dentists in the United States in 2005.

A March 2008 study funded by the California HealthCare Foundation confirmed what the ADA has been saying for some time – to improve dentists' participation in Medicaid, the States must do three things.

- improve the Medicaid fees;
- ease administrative burdens (make it look more like the private sector); and
- involve state dental societies and individual dentists as active partners in improving the program.

Many Medicaid fees are well below what it costs the dentist to provide the care. In addition, applications to become a Medicaid provider and other paperwork requirements (such as claims submissions) are often quite different from the paperwork necessary to participate in private

sector plans. All of this adds to the cost of providing care and might result in errors that trigger costly reviews. All of these serve as disincentives for private practitioners to participate.
The California HealthCare Foundation report examined six states (Tennessee, Washington, South Carolina, Virginia, Alabama, and Michigan) where the number of participating dentists and patients seen rose significantly. For purposes of this testimony, we discuss Michigan's "Healthy Kids Dental" (HKD) program in some detail because we have a good deal of information on the program (see attachments) and the program best illustrates how the Centers for Medicare and Medicaid Services (CMS) and Congress can encourage needed changes to the dental Medicaid program to increase the number of dentists providing services to children enrolled in Medicaid.

The Michigan Dental Association, the Michigan Department of Community Health, and Delta Dental of Michigan, Ohio and Indiana joined together in 2000 and worked with their state legislature and governor to develop and expand the HKD program.

Under the HKD program:

- dentists' participation shot up from 25 percent to 80 percent in one year and now stands at 90 percent;
- the time it took a Medicaid recipient to travel to the dentist's office was cut in half, equaling the travel time of patients covered by private sector Delta Dental plans; and
- the number of children with a "dental home" under the HKD program far exceeds those with a dental home under the traditional Medicaid program in Michigan.

By all measures, the HKD program is a resounding success and should be emulated by other States to the maximum extent feasible.

We believe there is a great deal that Congress and CMS can do to encourage other States to take measures to follow Michigan's lead. For example, Congress can fund grants to facilitate such collaborative activities and CMS can issue guidance outlining how such collaborative activities have effectively worked in Michigan, Alabama, Tennessee, and other States. Also, the agency could send a letter to State Medicaid Directors requiring the directors to report on measures they are going to take to improve their dental Medicaid programs.

The ADA, for its part, has encouraged State dental societies to reach out to other stakeholders in this fashion and have touted the success stories of Michigan and some of the other States. In addition, the ADA believes passing H.R. 2472, "The Essential Oral Health Care Act of 2007", is important because the bill provides enhanced federal matching funds if a state is willing to increase Medicaid fees, address administrative barriers and reach out to the dental community.

In addition to bringing many more dentists into the Medicaid system, more needs to done to influence the distribution of those dentists to make sure they can serve the Medicaid population in a timely manner. This can be greatly facilitated by:

- incentives to get those dentists into underserved areas with student loan repayments and tax credits;
- grants to facilitate networking among local community officials and private sector dentists who want to practice in a rural underserved community as a means of helping the local communities help themselves.

Finally, there need to be initiatives that strengthen the oral health delivery system. To accomplish this goal, the ADA recommends the following:

- The ADA supports adjustments in the dental workforce, including Community Dental Health Coordinators. The CDHC will be a new allied dental provider who will enable the existing dental workforce to expand its reach into underserved communities. They will be competent in developing and implementing community-based oral health prevention and promotion programs; providing individual preventive services (such as fluoride and sealant applications); and performing temporization on dental cavities with materials designed to stop the cavity from getting larger (and alleviating pain) until a dentist can see the patient.
- The ADA also supports adequate funding of oral health infrastructure (including community-based water fluoridation and sealant programs), oral health education programs, and the efforts by Health Centers to provide care to all regardless of ability to pay.
- Finally, there is still a role for voluntary programs to deliver free or discounted oral health care to underserved children.

Testimony

Chairman Kucinich and members of the subcommittee, the American Dental Association (ADA), whose 155,000 members represent more than 72 percent of the dental profession, thanks you for holding this hearing and calling attention to the need for improving access to oral health care for America's children.

My name is Dr. Jane Grover, first vice president of the ADA and the Dental Director for the Center for Family Health (CFH). The CFH is a federally qualified health center (FQHC), dedicated to serving Jackson County, Michigan, and provides primary health care, including prenatal, pediatric, adolescent, adult, geriatric, behavioral health and dental care. The CFH serves all members of our community, regardless of their ability to pay. As director of a dental program in an FQHC and an experienced private practitioner before that, I understand the problems with the dental Medicaid program (both from the private and public practitioner perspective) and the challenges faced by underserved populations and oral health care providers. I am pleased to have this opportunity to appear before the subcommittee today to share some of these experiences.

Last year, the nation was shocked by the death of 12 year old Deamonte Driver—who lived only a short drive from here—from a brain infection apparently related to untreated dental disease. Clearly, the oral health care system failed this young man. All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us.

The impact of poor oral health can go far beyond the mouth. It is well documented that untreated oral health can lead to oral infections that can affect systemic health. New evidence of this is emerging all the time. Oral bacteria have also been associated with bacterial pneumonia in bed or chair-bound patients, and might also be passed from mother to child resulting in a higher prevalence of caries (tooth decay) in these children. Although it's not clear if treating an oral disease will improve specific health problems, we do know that oral health is important for overall health and vice versa.

Fundamental changes to the Medicaid program are long overdue to prevent the possibility of future tragedies like Deamonte and to ensure that all low-income children have the same access to oral health care services enjoyed by the majority of Americans.

Barriers to Accessing Oral Health Care Services

There are many barriers to providing every child from a low-income family in America with good oral health care services. Some of the barriers make it difficult to supply care (such as the geographic distribution of providers), some affect the demand for services, but all of them impact the ability of the underserved children to access dental services.

Supply Side Activities

According to the American Dental Education Association (ADEA) growing demand for dental care has resulted in the scheduled opening of eight new dental schools (in addition to the current 57 schools) in the next few years and beyond. This will include schools in Arizona, North

Carolina (in the eastern part of the state with a focus on rural access), Utah, Nevada, Texas, Wisconsin, Virginia, and New England. These new schools will significantly increase the number of dentists trained in the future and will go a long way towards addressing the needs of a growing population and providing care to underserved populations.

In addition to increasing the number of dentists in the nation the ADA recognizes that adjustments in the dental workforce are necessary to more effectively address the special needs of underserved communities, especially children. To help bring about these needed changes the ADA has created and is promoting the development of a new member of the dental team – the Community Dental Health Coordinator (CDHC). The CDHC will be a new allied dental provider who will enable the existing dental workforce to expand its reach into underserved communities.

These new oral health providers will be recruited from underserved dental areas and will share their communities' cultural values. CDHCs will be competent in developing and implementing community-based oral health prevention and promotion programs; providing individual preventive services (such as fluoride and sealant applications); and performing temporization of cavities with materials designed to stop the cavity from getting larger (and alleviating pain) until a dentist can see the patient.

In addition, they will learn skills necessary to reach out to underserved communities and make sure children previously unable to access the oral health delivery system are seen by a dentist.

The CDHC can be employed by Health Centers, the Indian Health Service, public health clinics or private practices.

If there had been a CDHC in the school that Deamonte Driver attended, we believe this tragedy could have been prevented. Through a routine exam, a CDHC could have spotted a simple cavity, filled the cavity with a temporary filling, and made arrangements for care by a dentist. If the CDHC had not come in contact with Deamonte until the cavity had become an abscess, the CDHC could have made immediate arrangements to get Deamonte emergency care. This committee heard testimony last year about how difficult it was for Mrs. Driver to find dentists who take Medicaid patients. The CDHC will be trained to help families enroll in the state Medicaid program, help them get transportation to appointments, and will follow up after treatment.

Congressional Action

Increasing the number of dentists nationally and expanding the dental team will definitely help to address dental access problems. But Congress needs to act to effectively reform oral health care under Medicaid. No matter who is providing the care, it is clear that the majority of the dental Medicaid programs are woefully under funded. Congress can take a positive step in addressing that problem by passing the "Essential Oral Health Care Act of 2007", H.R. 2472, which will provide enhanced federal matching funds to states willing to increase their fees and address administrative barriers and other impediments to ensuring provider participation.

The goal of H.R. 2472, which now has more than 55 co-sponsors, is to attract more private sector dentists into the Medicaid and SCHIP programs (over 90 percent of all practicing dentists are in the private sector), which is necessary if we are to truly address the problem. Under H.R. 2472, a State is offered a 25 percentage points increase (not to exceed 90 percent) of the Federal Medical Assistance Percentage (FMAP) with respect to expenditures for dental and oral health services for children if the State is willing to ensure the following:

1. Children enrolled in the State plan have access to oral health care services to the same extent as such services are available to the pediatric population of the State;
2. Payment for dental services for children under the State plan is made at levels consistent with the market-based rates;
3. No fewer than 35 percent of the practicing dentists (including a reasonable mix of general and pediatric dentists and oral and maxillofacial surgeons) in the State participate in the State plan and there is a reasonable distribution of dentists serving the covered population;
4. Administrative barriers are addressed, including improving eligibility verification, ensuring that any licensed dentist may participate in the publicly funded plan without having to participate in other plans, simplifying claims processing, assigning a single plan administrator for the dental program, and employing case managers to reduce the number of missed appointments; and
5. Educating caregivers regarding the need to seek dental services and addressing oral health literacy issues.

There currently are many federal dental programs that also work primarily at the state level to strengthen the dental safety nets. Each year, the ADA and other national dental organizations work to ensure adequate funding and administrative support for the Health Resources and Services Administration's Health Professions Education and Training Programs[1]; HRSA's Maternal and Child Health Bureau (MCHB)[2]; the Centers for Disease Control and Prevention's

[1] Health professions education and training programs have a critical role in the recruitment and retention of minority and disadvantaged students and faculty. These programs are crucial if we are to address concerns with health disparities.

[2] Specifically, oral health projects in the Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), Title V, Special Projects of Regional and National Significance (SPRANS) account.

Division of Oral Health[3]; the National Institute of Dental and Craniofacial Research (NIDCR)[4]; the Ryan White HIV/AIDS Dental Reimbursement Program (Part F, Ryan White CARE Act) [5] ; and most significantly, the Title VII general, pediatric and public health dentistry residency programs within HRSA.[6] We call upon Congress to properly support these vital programs as part of our collective effort to fix the access problems for children from low-income families and other underserved.

Congress can also pass new laws that address mal-distribution problems of dentists that impede access to oral health care. The ADA has long supported incentives at the federal level to encourage private sector dentists to establish practices in underserved areas. For example, the Association advocates for tax credits as inducements to help bring dentists to underserved areas, as well as programs to help connect local elected officials and business people from underserved rural communities with dentists who want to practice in those communities. Local officials and business people willing to help underwrite a private dental practice in an underserved rural area by, for example, helping to defray the cost of setting up an office can be a very effective way of targeting resources to address a specific need and does not require an extensive, cumbersome

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[3] The Centers for Disease Control and Prevention's Division of Oral Health (DOH) supports state- and community-based programs to prevent oral disease, promote oral health nationwide and foster applied research to enhance oral disease prevention in community settings. The CDC works with states to establish public health research that provides valuable health information to assess the effectiveness of programs and target populations at greatest risk. In addition, through the DOH, states can receive funds to support prevention programs that aim to prevent tooth decay in high-risk groups, particularly poor children, and reduce oral health disparities.

[4] NIDCR is the only Institute within the NIH that is committed to oral health research and training. Institute-sponsored research continues to link oral infection to such systemic diseases as diabetes, cardiovascular disease (heart attack and stroke) and adverse pregnancy outcomes (preterm birth and low birth weight). The Institute remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research.

[5] The Ryan White HIV/AIDS Dental Reimbursement Program increases access to oral health services for people living with HIV/AIDS; ensures that dental and dental hygiene students and dental residents receive the most current training; and assist in defraying the rising non-reimbursed costs associated with providing such care by dental education institutions.

[6] Title VII dental residency programs are instrumental in training dentists who work in underserved communities and treat Medicaid, SCHIP or other underserved populations, particularly those with special needs.

federal government program. The federal government can be helpful in facilitating such arrangements by providing grants to set up networks that match interested local communities and dentists.

The ADA also works with and supports our colleagues who practice in Health Centers, which receive Section 330 funding in exchange for providing care to all regardless of ability to pay. We have an excellent working relationship with the National Association of Community Health Centers (NACHC) and encourage our private sector members to work cooperatively with the centers in their communities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers, thereby providing the centers with another option to efficiently provide dental services to Health Center patients when and where those services are needed. Last year's SCHIP legislation contained a provision that clarified such arrangements are legal.

Rep. Elijah Cummings, a member of this Committee, has also introduced a bill which the ADA supports and believes could improve pediatric dental care in Health Centers. H.R. 2371, "Deamonte's Law", would provide increased funding to allow the centers to hire more pediatric dentists. It would also increase the number of pediatric dental training programs in the country.

Rep. Cummings also added a provision to the SCHIP legislation last year that called for ensuring that all new mothers that qualify for Medicaid or SCHIP receive educational information on pediatric oral health care shortly after giving birth. The ADA strongly supports this initiative and hopes that Congress can include it in the next SCHIP bill.

Non-governmental Activities

Dentists understand their ethical and professional responsibilities. In the absence of effective public health financing programs, many state dental societies joined with other community partners to sponsor voluntary programs to deliver free or discounted oral health care to underserved children. According to the ADA's *2000 Survey of Current Issues in Dentistry*, 74.3 percent of private practice dentists provided services free of charge or at a reduced rate to one or more groups (e.g., homebound, handicapped, low income). A total national estimate of the value of this care was $1.25 billion, or $8,234 per dentist. In 2003, the ADA launched an annual national program called "Give Kids A Smile". The program reaches out to underserved communities, providing a day of free oral health care services. "Give Kids A Smile" helps educate the public and state and local policymakers about the importance of oral health care while providing needed and overdue care to large numbers of underserved children. The ADA's sixth annual Give Kids A Smile event on February 1, 2008, was again highly successful. More than 47,000 dental team members registered to participate. Nationwide, 1,800 programs were held. This program treated about 500,000 children. The estimated value of that care was over $29.8 million. Poor children shouldn't have to depend on charity for basic dental care. These efforts are important but are no substitute for fixing the Medicaid program.

Demand Side Activities

In the testimony above, we commented on the SCHIP provision promoted by Rep. Cummings to provide new mothers with oral health information. University researchers seeking to identify the barriers to oral health care faced by caregivers for low-income individuals concluded that efforts

need to be made to educate caregivers about the importance of oral health to overall health. [7] The ADA and other professional dental organizations agree that early intervention is very important in assuring that a child has good oral health. Accordingly, the ADA recommends that children see a dentist for the first time within 6 months of the appearance of the first tooth and no later than the child's first birthday.[8] The American Academy of Pediatric Dentistry also recommends that all children should visit a dentist in their first year of life and every six months thereafter, or as indicated by the individual child's risk status or susceptibility to disease.[9]

The ADA also has a number of initiatives it is undertaking to address oral health literacy issues. They include: implementing an advocacy strategy to increase the number of school districts requiring oral health education for K-12 students; encouraging the development of oral health literacy continuing education programs to train dentists and allied dental team members to communicate effectively with patients with limited literacy skills; and developing guidelines for the creation of educational products to meet the needs of patients with limited literacy skills, including involving targeted audiences to help develop materials.

Challenges Associated with the Medicaid Program

To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid because over 90 percent of all

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[7] S.E. Kelly; C.J. Binkley; W.P. Neace; B.S. Gale, "Barriers to Care-Seeking for Children's Oral Health Among Low-Income Caregivers," *American Journal of Public Health*, Aug 2005; 95, 8; Alumni – Research Library, pg. 1345.

[8] American Dental Association, ADA statement on early childhood caries, 2000. Available from: www.ada.org/prof/resources/positions/statements/caries.asp

[9] American Academy of Pediatric Dentistry, Guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Available from: www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

practicing dentists are in the private sector (totaling over 162,000). Safety net facilities that target underserved populations are, of course, very important but they employ relatively few dentists. Efforts to expand care *only* through safety net facilities will not fix the access problem. For example, in fiscal year 2007, Health Centers receiving Section 330 funding employed about 2,107 (FTE) dentists.[10] Even after significant growth in Health Centers in the past several years, that is still less than 2 percent of the total of 177,686 active dentists in the United States in 2005.[11]

Seventy-five percent of Medicaid enrollees are children and their parents and about half of the program's 60 million 2006 enrollees are poor children, making it the federal government's largest health care program in terms of enrollment. [12] At the same time, according to the Congressional Budget Office (CBO), many eligible people do not enroll in the program and there have been estimates that about 33 percent of the 10 million children identified as uninsured are eligible for Medicaid. [13] So, experts estimate that more than 30 million American children meet Medicaid eligibility requirements.

There are a number of factors that work against bringing more private sector dentists into the Medicaid program – but they can be overcome if we work together. As CBO points out, analyses of Medicaid's reimbursement rates have found them to be lower than Medicare or private insurance rates.[14] This was also discussed in a General Accountability Office study,

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[10] DHHS, HRSA, BPHC, 2007 Uniform Data System.
[11] American Dental Association, Survey Center.
[12] Congressional Budget Office, Medicaid Spending Growth and Options for Controlling Costs, Statement before the Special Committee on Aging, July 13, 2006, pp. 1-3.
[13] T.M. Selden, J.L. Hudson, and J.S. Ban thin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, vol. 23, no. 5 (September-October 2004), pp. 39-50.
[14] CBO, Ibid. at p. 4.

which recognized a number of administrative barriers. [15] More recently, a July 2008 report funded by the Kaiser Commission on dental Medicaid and SCHIP stated that Medicaid rates often do not cover dentists' costs of providing care and that overhead costs (60 cents of every dollar earned) exceed those of most physicians. [16]

In short, the vast majority of the dental Medicaid programs in the United States are woefully under funded and the reimbursement rates simply cannot attract enough dentists as they do not cover overhead costs. Where these programs have been enhanced, the evidence is clear that dentist participation increases significantly. In addition, high student debt pressures young dentists to go into the private sector and makes it fiscally less feasible to take public health or clinic positions. Significantly, the American Dental Education Association reported that indebtedness for dental school graduates averaged $172,627 for 2007, with public school graduates averaging $148,777 and private/State-related school graduates averaging $206,956. This level of debt puts a great deal of pressure on young dentists to set up private practices in relatively affluent areas to the exclusion of underserved areas.

Solutions at the State Level

In a March 2008 study funded by the California HealthCare Foundation[17] the authors concluded that to improve the dental Medicaid program fee increases are necessary, but there must also be an easing of administrative processes and an effort to involve state dental societies and individual

[15] General Accounting Office, "Oral Health … Factors Contributing to Low Use of Dental Services by Low-Income Populations," September 2000. p.4.
[16] National Academy for State Health Policy, The Kaiser Commission on Medicaid and the Uninsured, "Filling an Urgent Need: Improving Children's Access to Dental Care in Medicaid and SCHIP", July 2008.
[17] California HealthCare Foundation, "Increasing Access to Dental Care in Medicaid: Does Raising Provider Rates Work?" March 2008.

dentists as active partners in improving the program. The report examined six states (Tennessee, Washington, South Carolina, Virginia, Alabama, and Michigan) where the number of participating dentists and patients seen rose significantly. The factors that contributed to the success experienced by those states were discussed in the context of the California program, where patient utilization and provider participation are low.

Providing details on a very successful dental Medicaid program -- a September 2008 study of the first six years of Michigan's "Healthy Kids Dental" (HKD) Medicaid program[18] concludes that access to dental care continues to improve; an increasing proportion of children receive dental care each year from local providers close to home; and many of the children in the program appear to have a dental home and are entering regular recall patterns. The HKD program is administered by Delta Dental of Michigan, dentists are paid usual delta PPO fees, the child may select any participating dentist, the standard Delta claims administration is used, and there are no co-payments or annual maximums. In other words, it looks just like many of the private sector plans accepted by the dentists in the counties covered by the HKD program.

According to Dr. Eklund[19], introduction of the HKD program precipitated a dramatic rise in the number of dentists participating in the Medicaid program. Before HKD, in 2000, fewer than 25 percent of the dentists participated in Medicaid within the counties that were later covered by the HKD program. Within one year of the introduction of HKD in 2001, that number rose to over 80 percent participation and by 2005 dental participation was over 90 percent within the same

[18] S.A. Eklund, Michigan's Medicaid "Healthy Kids Dental" Program, University of Michigan School of Public Health, September 4, 2008 (see attachments).
[19] Stephen A. Eklund, D.D.S., M.H.S.A., DrPH, Professor Emeritus, University of Michigan School of Public Health, Consultant to Delta Dental of Michigan, Ohio and Indiana.

counties that just four years earlier had been below 25 percent. As a consequence, according to Dr. Eklund, the amount of time it took a Medicaid recipient to travel to the dentist's office was cut in half, equaling the travel time of patients covered by private sector Delta Dental plans. The current HKD program was expanded to 61 of Michigan's 83 counties, effective July 1, 2008; however, the program still covers only about 33 percent of Medicaid eligible children because the traditional Medicaid program remains in place in some of the larger communities.

A comparison of the traditional Medicaid program, the HKD program, and the private sector Delta plans clearly shows that dramatic positive effects on access have taken place for the children under the HKD program. For example, the HEDIS[20] measure of annual dental visits for the traditional program (2004) was just over 36 percent for children ages 2 to 21, while the HKD (2004) HEDIS measure was over 52 percent, rising to over 56 percent by 2007, which is much closer to the well established Delta plans, which registered a 71 percent HEDIS measure for its largely middle class population. Also, implementation of the HKD program has greatly increased the number of children with a "dental home" (defined as two or more preventive visits with the same dentist in a year). In 2007, the percent of HKD children (enrolled in the program for 12 months) with a dental home was 29.9, which compares favorably to the 36.5 percent of Delta children with a dental home when one considers the Delta plans have been around for many years and the populations served by those plans often have long standing relationships with their dentists.

[20] The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service, according to the National Committee for Quality Assurance.

Between October 2002 and October 2006, the number of dentists participating in the TennCare dental program grew by 112 percent and in rural counties by 118 percent.[21] This growth occurred after the dental program was "carved out" of the Medicaid medical program in 2002, whereby the dental care was administered by its own benefits manager and had its own funding stream, comprising 2 percent of the entire TennCare budget. The carve out facilitated the development of a good working relationship with the Tennessee Dental Association and other stakeholders, resulting in a streamlined dental administrative process, among other improvements. Four other states use a similar dental carve out system – California, Illinois, Massachusetts (in progress), and Virginia. Finally, the Alabama program (Smile Alabama!) has also significantly improved dentist participation. State officials note the increase in reimbursement rates and its outreach to dentists as significant contributing factors in growing that program. [22]

To be clear, the Association is not suggesting that the programs discussed above are the only ways to begin to address the oral health access problems facing low-income children – or even the best ways in all cases. We are simply suggesting that while the problems are considerable, they are not insurmountable if all parties work together.

In fact, the success of the "Healthy Kids Dental" program in Michigan illustrates what can be done when stakeholders work cooperatively toward a common goal. The Michigan Dental Association, the Michigan Department of Community Health, and Delta Dental of Michigan, Ohio and Indiana joined together and worked with their state legislature and governor to develop

[21] J. Gillcrist, "TennCare Dental Program: Before and After the Carve Out"
[22] Smile Alabama! "Alabama Medicaid's Dental Outreach Initiative."

and expand the HKD program. We believe there is a great deal that Congress and the Centers for Medicare and Medicaid Services (CMS) can do to encourage other states to take similar measures to improve their dental Medicaid programs through grants and other means.

Conclusion

All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us. Fundamental changes to the Medicaid program are long overdue to ensure that low-income children have the same access to oral health care services enjoyed by the majority of Americans. While we have made progress toward reducing the morbidity of oral disease, significant and persistent disparities continue to adversely affect underserved populations. The problems are numerous and complex, but they are not insurmountable. For too long, dental disease has been the "silent epidemic."

Mr. Chairman, our nation's most vulnerable citizens deserve better care than we have so far provided. The ADA stands ready to do its part, and we call upon our many friends in Congress to work with us to ensure that every child can face his or her future with a smile.

Michigan's Medicaid "*Healthy Kids Dental*" program

Stephen A. Eklund, DDS, MHSA, DrPH

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Consultant to Delta Dental of Michigan, Ohio and Indiana

September 4, 2008

Healthy Kids Dental Program

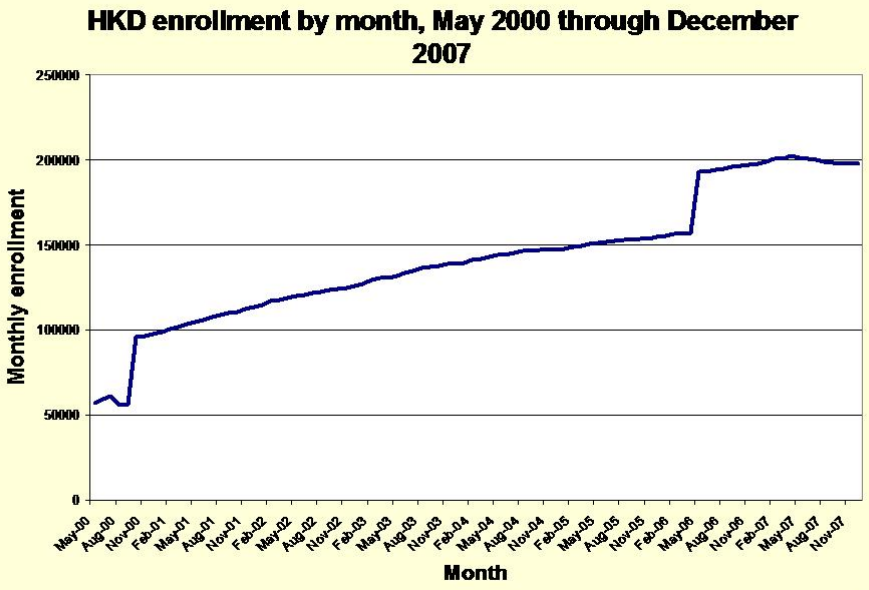
- *A*dministered by the Delta Dental of Michigan
- Dentists paid usual Delta fees, according to coverage type
- Child may use any participating provider
- Program eligibility based on child's county of residence, not location of the dentist
- Standard claims administration (same as for all other Delta patients)
- 100% payment (no patient co-payments)
- No annual maximum

Michigan Healthy Kids Dental

- Began on May 1, 2000 in **22** of Michigan's 83 counties
- Expanded to **37** counties on October 1, 2000
- Expanded to **59** counties on May 1, 2006
- Expanded to **61** counties on July 1, 2008

Michigan Healthy Kids Dental

- Initially 18 counties conventional fee for service, 4 counties PPO.
- Became 33 conventional fee for service and 4 PPO with first expansion.
- Four counties were changed to PPO on January 1, 2004, for a total of 8.
- All counties switched to the PPO fee structure on January 1, 2006 but dentists not required to become Delta PPO providers.



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Enrollment and Access

	Any enrollment		12 month enrollment		1 to 11 month	
Year	Enrolled	Users (%)	Enrolled	Users	Enrolled	Users
2001	162,678	48,714 (29.9)	55,536	27,226 (49.0)	107,142	21,448 (20.0)
2002	178,519	57,032 (31.9)	66,725	33,643 (50.4)	111,794	23,389 (20.9)
2003	192,327	63,856 (33.2)	76,673	39.437 (51.4)	115,654	24,419 (21.1)
2004	204,664	68,058 (33.2)	84,524	43,443 (51.4)	120,140	24,615 (20.5)
2005	213,447	74,027 (34.7)	90,003	47,831 (51.4)	123,474	26,196 (21.2)
2006	266,593	93,148 (35.0)	94,654	50,906 (53.1)	171,939	42,242 (24.6)
2007	273,850	101,637 (37.1)	120,974	66,718 (55.2)	152,876	34,919 (22.8)

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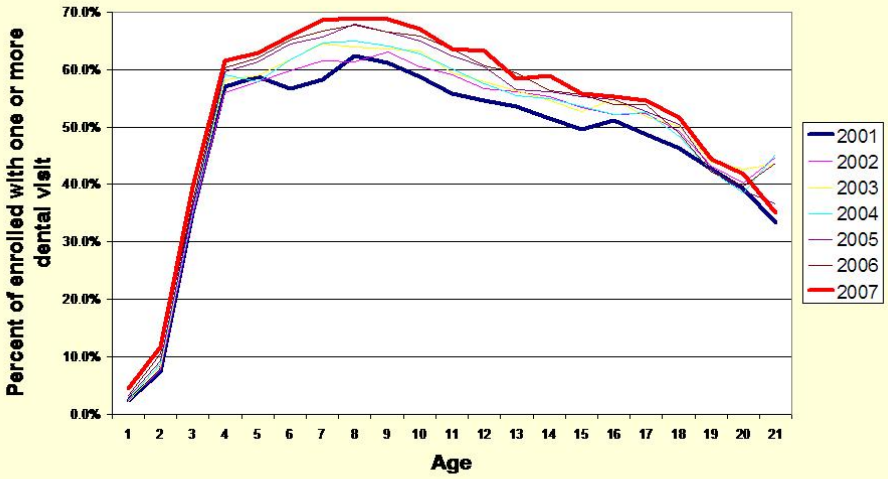
Michigan Healthy Kids Dental utilization of dental care, 12 month enrollment in calendar year, by age



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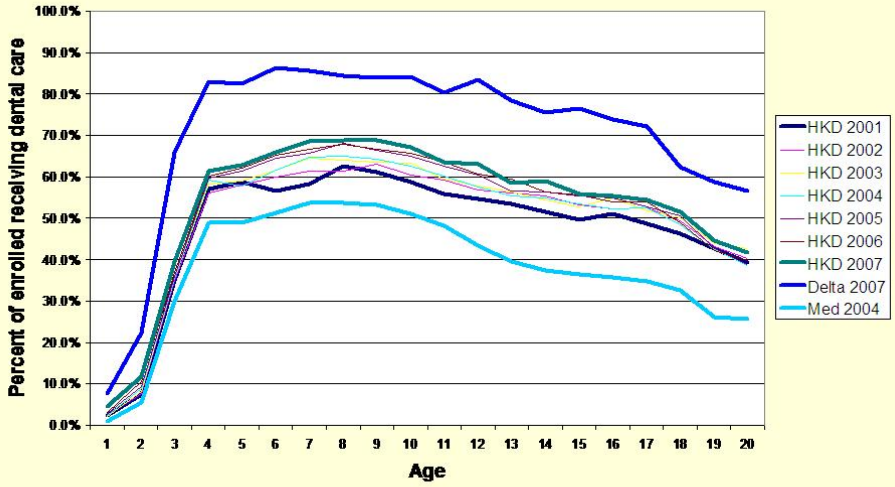
HKD, Medicaid, and Delta private utilization of dental care, 12 month enrollment in calendar year, by age



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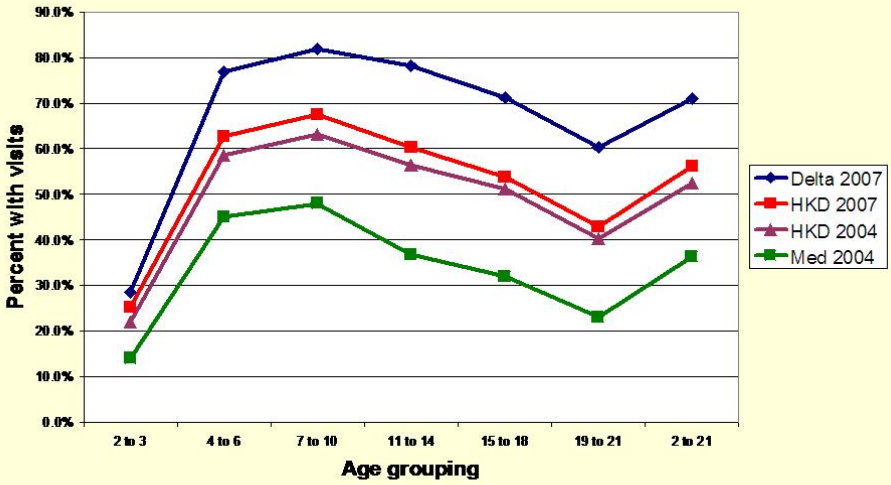
HEDIS Annual Dental Visit for HKD

Age	2001	2002	2003	2004	2005	2006	2007
2 to 3	20.4%	21.1%	21.7%	21.9%	22.4%	23.2%	25.3%
4 to 6	56.4%	57.2%	58.8%	58.5%	61.0%	61.8%	62.6%
7 to 10	59.5%	60.9%	62.9%	63.2%	65.5%	66.0%	67.5%
11 to 14	53.5%	56.2%	56.4%	56.5%	58.0%	59.4%	60.3%
15 to 18	48.9%	51.6%	51.8%	51.1%	52.9%	52.7%	53.8%
19 to 21	40.1%	42.6%	43.5%	40.3%	40.4%	40.8%	43.0%
2 to 21	50.0%	51.6%	52.5%	52.4%	54.2%	54.8%	56.2%

HEDIS Annual Dental Visit for Delta, HKD, and Medicaid

Age	Delta 2007	HKD 2007	HKD2004	Med 2004
2 to 3	28.5	25.3	21.9	14.0
4 to 6	77.0	62.6	58.5	45.0
7 to 10	82.0	67.5	63.2	48.0
11 to 14	78.3	60.3	56.5	36.7
15 to 18	71.2	53.8	51.1	31.9
19 to 21	60.3	43.0	40.3	23.0
2 to 21	71.0	56.2	52.4	36.3

HEDIS annual visit for HKD, Medicaid, and Delta commercial



Participating dentists

Number of dentists and number of children receiving treatment

Year	Dentists	Children treated (Children/dentist)	Child-dentist combinations (Children per dentist)
2001	1544	48,714 (31.6)	56,971 (36.7)
2002	1624	57,032 (35.1)	66,354 (40.9)
2003	1715	63,856 (37.2)	74,307 (43.3)
2004	1773	68,058 (38.4)	79,599 (44.9)
2005	1926	74,027 (38.4)	88,951 (46.2)
2006	2255	93,148 (41.3)	109,440 (48.5)
2007	2243	101,637 (45.3)	122,841 (54.8)

Dental Home

Two or more preventive visits with the same dentist in the year

Year	Number of HKD children with two or more preventive visits per year	Percent of HKD children with two or more preventive visits per year	Percent of Delta children with two or more preventive visits per year	Percent of HKD 12-month enrolled children with two or more preventive visits per year
2001	9,202	19.9	38.4	26.9
2002	12,138	22.8	38.0	29.7
2003	14,729	24.4	38.3	31.3
2004	16,365	25.4	38.7	32.0
2005	17,788	24.8	37.2	30.9
2006	20,099	22.8	35.9	31.6
2007	23,909	24.4	36.5	29.9

Procedures per user

Year	D&P	Resto	Endo	Perio	Pros	OSurg	Adj	Total
2001	4.24	1.51	0.09	0.01	0.00	0.31	0.03	6.19
2002	4.31	1.52	0.10	0.01	0.00	0.32	0.03	6.29
2003	4.41	1.50	0.10	0.01	0.00	0.31	0.03	6.36
2004	4.44	1.46	0.10	0.00	0.00	0.31	0.04	6.34
2005	4.53	1.45	0.09	0.00	0.00	0.32	0.04	6.45
2006	4.42	1.33	0.09	0.01	0.00	0.21	0.02	6.08
2007	4.58	1.35	0.09	0.01	0.00	0.22	0.02	6.27

Percent of total cost by major procedure code groupings

Year	D&P	Resto	Endo	Perio	Pros	OSurg	Adj
2001	41.7	38.5	7.0	0.4	0.3	10.8	1.3
2002	40.5	39.3	7.3	0.4	0.4	10.9	1.3
2003	41.4	38.8	7.2	0.3	0.3	10.8	1.3
2004	42.8	36.6	7.3	0.1	0.3	11.3	1.5
2005	42.2	36.1	7.1	0.1	0.3	12.4	1.8
2006	47.4	38.1	6.8	0.2	0.2	6.5	0.8
2007	47.4	37.6	6.8	0.3	0.3	6.8	0.9

Paid* per user

Year	D&P	Resto	Endo	Perio	Pros	OSurg	Adj	Total
2001	143.98	133.15	24.31	1.48	1.21	37.20	4.37	345.68
2002	151.85	147.42	27.25	1.56	1.38	40.83	4.79	375.08
2003	160.63	150.58	27.99	1.06	1.00	41.92	5.07	388.26
2004	160.50	137.50	27.46	0.40	1.14	42.41	5.78	375.19
2005	164.71	140.99	27.52	0.47	1.06	48.50	7.08	390.32
2006	139.08	111.85	20.11	0.70	0.61	19.04	2.33	293.71
2007	141.74	112.35	20.30	0.79	0.75	20.24	2.77	298.94

*All dollar amounts presented are adjusted for inflation using the 2007 All Item Consumer Price Index (CPI), and reported in 2007 dollars.

SUMMARY

- Access to dental care has continued to improve under HKD.
- The change to PPO fee levels in 2006 does not appear to have slowed the increase in access to care.
- More children and an increasing proportion of children receiving dental services each year.
- The number of dentists providing care continues to increase, leveling off on 2007.

SUMMARY - continued

- The number of children treated per dentist continues to increase.
- Children are receiving services from local providers close to home.
- Many *HKD* children appear to have a dental home and to be entering regular recall patterns.

Jane Grover, D.D.S., M.P.H.

First Vice President

Dr. Jane Grover has been Dental Director and Clinician for the Center for Family Health in Jackson, Michigan, since 2001. She is first vice president of the American Dental Association.

Between 1983 and 2001, Dr. Grover was in private practice as a general dentist. Prior to that, she served as Dental Director of the Jackson County Health Department in Michigan. She was also appointed by Michigan Governor Engler to the state's Health Plan Advisory Council and Maternal and Child Health Task Force and to the State Board of Dentistry for a four-year term.

She is an adjunct faculty member of the University of Michigan School of Dentistry, and of the Lutheran Medical Center in New York and has taught at Indiana University at South Bend. Dr. Grover has published in professional publications and made health policy presentations for national conferences and forums and in the media.

Dr. Grover received her dental degree from the UM School of Dentistry and her master's degree in public health from the UM Department of Health Services, Management and Policy. She and husband Robert reside in Jackson, MI, with their son Ryan.