WRITTEN
OF
TESTIMONY
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Domestic Policy Subcommittee
Oversight and Government Reform Committee
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2154 Rayburn HOB
10:00 a.m.

"Necessary Reforms to Pediatric Dental Care under Medicaid"

I, James J. Crall, D.D.S., Sc.D., hereby submit the following as written testimony pursuant to the Subcommittee's request for my views on policy reforms that have been proven to improve access to, and utilization or, pediatric dental care in Medicaid. This testimony concerns the hearing scheduled for Tuesday, September 23, 2008, at 10:00 a.m., in Room 2154 of the Rayburn House Office Building. My comments largely focus on (1) the impact of Medicaid reimbursement rate increases on dentists' participation and children's utilization of dental services in Medicaid and (2) the benefits of no-risk contractual arrangements that separate or 'carve out' Medicaid dental benefits from global Medicaid managed care arrangements. I thank the Subcommittee for the opportunity to participate.

1. Impact of Medicaid Reimbursement Rate Increases

a. Impact on Dentists' Participation in Medicaid

Access to an ongoing source of dental care is a critical component for maintaining good oral health in children. Access to regular, periodic dental care is especially important for children at elevated risk for tooth decay (dental caries), predominantly children in low-income families and children with special health care needs, who generally are covered by Medicaid. National surveys showing an increase in tooth decay in young children (what we now refer to as Early Childhood Caries or ECC) combined with the already large and growing numbers of children on Medicaid (nearly 30 million or 1-in-3 American children) underscore the need for engaging substantial numbers of dentists as Medicaid providers across the U.S. However, chronically low reimbursement to dentists for services rendered has been acknowledged by several private and governmental reports to be a major, if not the greatest, barrier to dentists' participation in Medicaid.

<u>Relationship between Reimbursement and Access to Dental Services for Children in Medicaid</u>

Access to dental services for children covered by Medicaid is a significant, chronic problem. Studies conducted by the U.S. Department of Health and Human Services[1] report that (a) relatively few

[1] Office of the Inspector General (OIG), U.S. Department of Health and Human Services. Children's Dental Services Under Medicaid: Access and Utilization. San Francisco, CA: U. S. Department of Health and Human Services, 1996.

children covered by Medicaid receive recommended dental services and (b) inadequate reimbursement is the most significant reason why dentists do not participate in Medicaid. Reports issued by the U.S. General Accounting Office[2,3] (GAO) to Congress in 2000 noted that Medicaid payment rates often were well below dentists' prevailing fees and that "as expected, payment rates that are closer to dentists' full charges appear to result in some improvement in service use."

The GAO's April 2000 Report to Congress compared a sample of dentists' fees in the private sector to Medicaid fees for the same services, and projected the proportion of dentists who might accept the Medicaid fees. The study indicated that the level of Medicaid dental reimbursement in 1999, nationally and in most States, was about equal to or less than the dental fees normally charged by the lowest 10th percent of dentists (the 10th percentile of respective fees) – i.e., 90 percent of dentists charged more, and usually substantially more, than the Medicaid fee. A subsequent assessment conducted in 2004 by myself and Dr. Don Schneider (former Chief Dental Officer at CMS) found that in 41 states, the majority of Medicaid dental reimbursement rates for common children's dental procedures remained below the 10th percentile and frequently were below even the 1st percentile of dentists' fees -- meaning that they were lower (and often substantially lower) than the fees charged by any dentist in the respective states.

Impact of Efforts by Some States to Establish Market-based Medicaid Reimbursement Rates

Beginning in the late 1990s, following a series of Oral Health Policy Academies organized by the National Governors Association, several states moved to increase Medicaid reimbursement levels to considerably higher levels consistent with the market-based approach advocated during the NGA Policy Academies. As shown in the table below, subsequent evaluations suggest that (similar to findings by the GAO) Medicaid payments that approximate prevailing private sector market fees do result in increased dentist participation in Medicaid.

STATE	**Adjustment to Medicaid Rates** (Market Benchmarks)	**Changes in Dentists' Medicaid Participation**	**Intervals After Rate Increases (months)**
Alabama	100% of Blue Cross rates	+39% +117%	24 44
Delaware	85% of each dentist's submitted charges	1 private dentist to 130 (of 378 licensed dentists)	48
Georgia	75th percentile of dentists' fees	+546% +825%	27 48
Indiana	75th percentile	+58%	54
Michigan Healthy Kids Dental	100% of Delta Dental Premier (16 counties)	+300%	12
South Carolina	75th percentile	+73% +88%	36 42
Tennessee	75th percentile	+81%	20

[2] General Accounting Office (GAO). Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations; U.S. General Accounting Office, Report to Congressional Requesters. HEHS-00-72, April 2000.

[3] General Accounting Office. Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations; U.S. General Accounting Office, Report to Congressional Requesters. HEHS-00-149, September 2000.

Other states, including Virginia, Texas and Connecticut also have taken steps to raise their Medicaid dental reimbursement rates to what are considered reasonable market-based rates. Unfortunately, as in the case of Connecticut and Texas, these changes often follow years of protracted federal litigation. The table below provides a comparison of Texas Medicaid payment rates for selected procedures and fees charged by dentists within the State of Texas and within the West South Central Region (AR, LA, OK, TX). Details of the data elements are summarized below.

TX Medicaid Payment Rates for Selected Procedures			Comparisons with Dentists' Claims for Insured Patients in the ADA West South Central (WSC) Region and in the State of Texas			
CDT4 Procedure Code	Procedure Description	TX Medicaid Payment Rate	WSC Region 50th Percentile	TX State 50th Percentile	TX State 75th Percentile	State Percentile Corresponding to TX Medicaid Payment Rate
Diagnostic						
D0120	Periodic Oral Exam	$14.72	$27.00	$28.00	$32.00	< 1st
D0150	Comprehensive Oral Exam	$18.02	$40.00	$40.00	$49.00	< 1st
D0210	Complete X-rays, with Bitewings	$36.04	$67.00	$65.00	$81.00	2nd
D0272	Bitewing X-rays - 2 Films	$11.93	$25.00	$25.00	$29.00	< 1st
D0330	Panoramic X-ray Film	$32.54	$65.00	$65.00	$75.00	1st
Preventive						
D1120	Prophylaxis (cleaning)	$18.75	$40.00	$42.00	$47.00	< 1st
D1203	Topical Fluoride (excluding cleaning)	$7.50	$19.00	$19.00	$22.00	< 1st
D1351	Dental Sealant	$18.55	$33.00	$35.00	$39.00	< 1st
Restorative						
D2150	Amalgam, 2 Surfaces, Permanent Tooth	$43.73	$88.00	$91.00	$107.50	< 1st
D2331	Resin Composite, 2 Surfaces, Anterior Tooth	$52.57	$110.00	$119.00	$135.00	< 1st
D2751	Crown, Porcelain Fused to Base Metal	$264.00	$650.00	$660.00	$725.00	< 1st
D2930	Prefabricated Steel Crown, Primary Tooth	$78.03	$152.00	$146.00	$175.00	< 1st
Endodontics						
D3220	Removal of Tooth Pulp	$43.98	$93.00	$95.00	$118.00	< 1st
D3310	Anterior Endodontic Therapy	$177.99	$420.00	$426.00	$509.00	3rd
Oral Surgery						
D7140	Extraction, Single Tooth	$33.52	$75.00	$79.00	$92.00	1st

The first two columns in the above table list procedure codes and descriptors for 15 procedures commonly used to assess Medicaid reimbursement rates for EPSDT services. The third column shows TX Medicaid payment rates in 2004 (which were largely unchanged since 1993 and remained unchanged until a federal court settlement in September, 2007). The next two columns show the median or 50th percentile charges for these services by dentists in the six states in the West South Central region and in TX; while the second column from the right shows charges representing the 75th percentile of fees charged by dentists in TX. The far-right column shows the percentile equivalents for the TX Medicaid rates (i.e., the percent of dentists who charge the same or lower amounts than Medicaid paid).

As an example, the table indicates that for a periodic oral examination, the regional and TX 50th percentiles of dentists' charges were $27 and $28, respectively. In 2004, the Texas Medicaid program paid $14.72 for that procedure, an amount that no dentist in TX would see as equal to or greater than their current charges (i.e., < 1st percentile). That is to say, 100% of TX dentists would see the Medicaid payment rate as less than their usual charges (substantially less for the majority of dentists). The same can be said for 10 of the other 15 selected procedures -- i.e., the respective Texas Medicaid payment amounts were less than the usual charges reported for any dentist in Texas, and below the cost of providing the procedure for the majority of Texas dentists. From an economic perspective, these payment levels which are substantially below prevailing charges of the vast majority of TX dentists and typical of Medicaid rates in many if not most other states, would not be expected to provide adequate incentives for dentists to participate in Medicaid.

In September, 2007, following a settlement in the federal court case of *Frew vs. Hawkins*, Texas EPSDT dental Medicaid reimbursement rates for 35 common procedures were raised by 100% (effectively to the 50th percentile of Texas dentists' fees). This followed more than a decade of essentially stagnant dental Medicaid rates in the face of steady modest increases in the cost of dental care (~ 4.5% annually). Significant increases also were provided for approximately 20 additional relatively common dental procedures. Information recently obtained from individuals involved in the *Frew* case indicates that within the first three months following the Medicaid reimbursement rate increase, approximately 500 Texas dentists applied to become new Medicaid providers.

Information obtained from these (and other) states which have implemented dental Medicaid reimbursement increases that brought their Medicaid payment rates into the range of what are considered to be 'reasonable market-based rates' have had a clearly positive impact on the number of dentists who provide dental services for children enrolled in Medicaid. Material regarding reimbursement rates and financing of dental services in Medicaid was included in the original version of the *Guide to Children's Dental Care in Medicaid* that was submitted by the American Academy of Pediatric Dentistry (AAPD) to the Centers for Medicare and Medicaid Services (CMS), but was redacted by CMS.

The entire section of the document that AAPD submitted to HCFA (CMS) on Program Financing and Payments (Section C in the submitted table of contents) was deleted from the published version of the Guide. Topics addressed within this section are delineated below.

C. Program Financing and Payments
    1. Funding Levels for Public Dental Programs for Children
    2. Actuarial Estimates of Necessary Funding Levels for Publicly-Financed Children's Dental Benefits Programs
        a. American Academy of Pediatrics Analysis
        b. Reforming States Group Analysis
    3. Historic Funding Levels in Public Pediatric Dental Care Programs
    4. Reimbursement for Dental Services
        a. U.S. General Accounting Office Study
        b. Comparisons of Medicaid Reimbursement Rates for Pediatric Dental Services to Prevailing Market Rates
        c. Global versus Selective Reimbursement Rate Adjustments
        d. Periodic Reimbursement Rate Adjustments

5. General Financing Considerations for Medicaid/EPSDT Dental Program Improvements

Additional information was provided in the *Guide* on comparisons of Medicaid dental expenditures vs. expenditure levels for the general population of U.S. children, along with summaries of relevant actuarial studies that had been conducted on behalf of the American Academy of Pediatrics and the Milbank Memorial Fund. These analyses showed that roughly $14-$17 per enrolled beneficiary (often referred to as PMPM or per-member-per-month) would be necessary to pay for dental services for children enrolled in Medicaid at market rates comparable to those used by commercial dental benefit plans for employer-sponsored groups. Typical benefits administration rates would raise those levels to $17-$20 PMPM for administering a Medicaid dental benefits program -- i.e., if states were to contract with dental benefits managers to administer the benefits. A subsequent actuarial analysis commissioned by the American Academy of Pediatric Dentistry generally affirmed those findings. This information was included to provide a guide or benchmarks that state Medicaid programs could use to assess their current allocation levels for dental benefits for children enrolled in Medicaid. Available information suggests that many states allocate only a small fraction of the financial resources suggested by these actuarial studies (e.g., on the order of $5-$7 PMPM).

b. Impact of Medicaid Reimbursement Rate Increases on Children's Use of Dental Services

Perhaps more directly to the point, the table below shows data from CMS 416 annual reports illustrating significant increases in utilization of dental services by children covered by Medicaid in five states following significant reimbursement rate increases. These increases in use of dental services also constitute a significant positive impact of Medicaid dental reimbursement rate increases.

	FY1998 CMS 416 % with Dental Visits	FY2001 CMS 416 % with Dental Visits	2001 vs. 1998 CMS 416 % with Dental Visits	FY2003 CMS 416 % with Dental Visits	2003 vs. 1998 CMS 416 % with Dental Visits
AL	41,659	105,522	253%	151,581	364%
DE	8,428	15,430	183%	18,269	217%
IN	47,730	160,627	337%	212,909	446%
SC	96,590	88,523	92%	245,297	254%
TN	148,028	141,140	95%	249,252	168%

2. Advantages of No-risk Contractual Arrangements that Separate or 'Carve Out' Medicaid Dental Benefits from Global Medicaid Managed Care Arrangements

In addition to the essential step of raising Medicaid dental reimbursement rates to reasonable market-based levels, many states have taken steps to implement no-risk, administrative services only (ASO) contracts that separate or 'carve out' dental Medicaid benefits from global Medicaid managed care arrangements. Examples include Michigan's Healthy Kids Dental Program and dental Medicaid programs in Tennessee, Virginia and Connecticut. These arrangements eliminate the need for subcontracting between global Medicaid managed care organizations (which often are not in the business of providing dental benefits) with dental benefits managers, allow States to retain greater control in setting reimbursement rates, and allow for reasonable profits on the part of dental benefits managers while eliminating incentives to reduce payments to dentists' who provide dental services to Medicaid beneficiaries. Additional advantages of this approach from the dentists' perspective include more streamlined enrollment procedures (because dentists do not need to fill out multiple enrollment forms and undergo credentialing by multiple dental benefits management organizations) and less confusion about multiple rules governing allowable services and billing processes that results from having multiple dental benefits intermediaries involved within the same State (and often the same geographic region within the State).

Additional benefits of this more streamlined approach include less confusion on the part of Medicaid beneficiaries. And, in addition, having a single dental Medicaid intermediary (single vendor) makes for easier contracting, monitoring and contract enforcement for the State Medicaid program.

Summary and Conclusions

In summary, several States have taken significant steps to increase dentists' participation and access to dental services in their Medicaid EPSDT programs over the past decade. Successful efforts generally have involved the necessary step of raising Medicaid dental reimbursement rates to reasonable market-based levels combined with steps to make program participation more 'dentist friendly'. Streamlining provider enrollment and implementation of no-risk contractual arrangements that separate or carve out Medicaid dental benefits contracting from global Medicaid managed care arrangements have been prominent parts of these strategies. Adoption of these strategies by other States would be expected to greatly improve children's access to dental care in Medicaid.

Thank you for the opportunity to participate in this hearing.

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