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Mr. Chairman, Ranking Member Jordan and Members of the Subcommittee,

I appreciate the opportunity to come before you today to testify about the federal government's roles and responsibilities in ensuring that children in Medicaid have access to the dental care that is entitled to them by federal law. I am Dr. Burton Edelstein, professor of dentistry and health policy at Columbia University and Founding Chair of the Children's Dental Health Project (CDHP), a DC-based independent non-profit organization committed to improving children's access to oral health.

I founded CDHP in 1997 in response to Congressional enactment of the State Children's Health Insurance Program (SCHIP). As a Robert Wood Johnson Foundation Health Policy Fellow in the office of Senate Minority Leader Tom Daschle, I had the opportunity to work on the SCHIP legislation throughout its development and was shocked by the lack of attention that children's oral health received at the time. The only mention of oral health in the legislation was the option that states were given to provide children with dental care. CDHP's original goal was to encourage states to adopt this optional dental benefit for children. Ultimately all states did so.

At the time of SCHIP enactment, Key Members of Congress and their staff were unaware that dental caries remains the single most prevalent chronic disease of U.S. children, five times more common than asthma, as later reported by the Surgeon General. It was not known that tooth decay affects nearly half of all children before they enter kindergarten, as later evidenced by CDC data. Congress was also unaware that tooth decay, when severe, causes children impairments in eating, speaking, and attending to school. This Subcommittee and others had not yet investigated the tragic and avoidable death of 12-year-old Deamonte Driver who succumbed to complications of an ordinary dental abscess.

By time Congress passed Children's Health Insurance Program Reauthorization Act (CHIPRA) earlier this year and took up Healthcare Reform in the Spring, work by this Subcommittee and others had insured that policymakers in Washington are finally demonstrating a clear understanding of the importance of oral health. I commend the Chairman for his leadership on this issue.

Because Congress now understands the importance of oral health, we have achieved key victories for children in CHIPRA. As in Medicaid, CHIP now requires comprehensive dental coverage. Parents of newborns whose delivery was paid by Medicaid and CHIP will now receive information on how to prevent early childhood caries before they leave the hospital. Reporting and accountability standards are now raised in both Medicaid and CHIP. And parents are now able to identify those few dentists who do participate in Medicaid through the federal "InsureKidsNow" website and telephone resource. A newly commissioned GAO study will further explore why so few dentists care for children in Medicaid and will address the potential for new midlevel dental providers to expand access.

This momentum has now led to significant gains in draft healthcare reform legislation. To date, all five committees of jurisdiction in the U.S. House of Representatives and U.S. Senate have included a mandatory pediatric dental benefit in the essential benefits package. Further,

Representative G.K. Butterfield of North Carolina has secured an amendment in the Energy and Commerce Committee that would require the Secretary of Health and Human Services to report to Congress after one year of enactment on the need and cost of including dental coverage for adults in the essential benefits package. We believe this is an excellent first step in addressing the extreme unmet need for dental care in the adult population that currently lacks dental coverage.

We were also extremely pleased to see a key CDHP-supported amendment offered by Representatives Diana Degette of Colorado, John Sarbanes of Maryland and Jerry McNerney of California that adds an oral health expert to any health benefits advisory committee. Because of the historic separation of oral health delivery and financing from the traditional medical system, the importance of oral health is often overlooked. For this reason, the inclusion of an oral health expert on any health benefits advisory committee will be critical.

Finally, we are pleased to see the provisions in both the House Tri-Committee and Senate Health, Education, Labor and Pensions (HELP) Committee bills that expand training programs for dentists and fund demonstration grants for midlevel providers. The Senate HELP bill also includes several critical public health provisions that would impact oral health. It creates a public education campaign; demonstration grants for dental caries management; school-based dental sealant programs in all 50 states; allows school-based health centers to use funds for dental programs; and authorizes CDC grants to improve oral health.

Yet for all this progress, great challenges still remain. The most recent GAO report under consideration by this Subcommittee today reports that dental care for children in Medicaid remains wholly inadequate despite a number of efforts by both CMS and State Medicaid authorities. To quote the report, "Access rates remain low… [and] longstanding barriers to children's access to dental services and barriers to dentists' participation in Medicaid hinder further improvement." As a result of these barriers, only a quarter of children in Medicaid saw a dentist in 2000 and today only a third obtains dental care - leaving the majority of child beneficiaries still with unmet dental needs.

The level of attention paid to children's oral health in CHIPRA and in healthcare reform needs to extend to ensuring that Medicaid is made to work for children, their families, and their dentists. Two and a half years after this Subcommittee first launched its investigation, children like Deamonte Driver still live among us and still suffer needlessly from dental conditions that are fundamentally preventable.

At the time that I founded CDHP, the vast majority of advocacy on behalf of oral health was conducted by organizations representing dentists. This makes sense, as dentists are on the front lines of providing dental care. However, dentists – like parents and program officials – both contribute to and can help solve the woeful inadequacy of dental care for children in Medicaid. When asked how to improve access to care, groups representing dentists have long advocated for a policy agenda that can be framed into three main categories: better payment, streamlined paperwork and improved patient compliance – with payment being the most emphasized.

Unfortunately, we have seen in states across the nation that addressing these three issues does not lead to the hoped for increase in access or utilization.

Raising reimbursement rates to appropriate levels so that payments represent more than governmental subsides to charitable care is a necessary but not sufficient solution to improving dental access. For example, an analysis by the California Healthcare Foundation of four state's experience in raising dental reimbursements reported that substantial fee improvements did increase utilization - but only from an average of 24% to an average of 32% after two years.

More detailed studies currently underway by my research group at Columbia University substantiate that during the period 1999-2006, 41 states reported fee increases but only 25 of these states also showed an increase in utilization, likely because the others' increases were insufficient. No state experienced improvements in utilization if they did not also raise fees at some time during this period and many of these state reforms also included reductions in paperwork and improved client assistance in making and keeping appointments.

Among the 25 states whose fee increases are associated with utilization increases, however, only 13 reached utilization levels of 33% or more. Overall, by 2006, 20 states still provided dental care to fewer than one-third of enrolled children and no state reached more than 45% of children. While these low treatment rates may suggest that parents fail to seek care when available, that is an unlikely explanation as the majority of children in Medicaid obtain one or more primary medical care visits in a year.

Notable in the Columbia study were some states, particularly those that are rural or frontier, in which utilization rates exceed the national average despite lower than average fees. Conjectured is that in such states the professional culture, role of dentists in their communities, lower dentists' operating costs, personal relationships, and/or larger proportion of children in Medicaid lead to more equitable care across income strata.

<u>If we know that payment, paperwork and patient compliance are not the only answers, the question then becomes, why aren't dentists seeing Medicaid patients?</u>

Contributing to the problem of dentist availability for children in Medicaid are:

- a relative decline in the numbers of dentists as the profession ages, the U.S. population expands, and the training of new dentists fails to keep up;
- the advent of elective, cosmetic dentistry that has crowded out some basic reparative capacity in the dental delivery systems;
- geographic, sociocultural, and language dislocations between primary care dentists and child populations with greatest needs. (The 2008 American Dental Association Medicaid Symposium noted that "participants felt that dental students and many current practitioners have not been adequately exposed to underserved populations during their training. Many are misinformed about the … Medicaid population…leading to dentists unknowingly being culturally insensitive.");
- the recession's pressure on state government to control Medicaid expenditures as Medicaid is a countercyclical program that faces greatest demands even as state revenues decline;

- the numbers of states that put their dental vendors at financial risk for increases in utilization since profits decline when utilization increases. (This problem was clearly evidenced in Georgia when vendors cut providers from their networks to ward off utilization increases.);
- the need for greater training of new dentists in the care of children and underserved populations. (The American Dental Education Association's graduating dental student survey for the class of 2006 reports that 1-in-9 new graduates feel less than fully prepared to treat children, 1-in-6 to provide oral health care to a diverse society, and 1-in-5 to provide oral health care in rural areas.)
- unwillingness of some dentists to treat Medicaid beneficiaries. (The peer reviewed dental literature substantiates negative attitudes toward Medicaid and its beneficiaries. The ADA Medicaid Symposium reported that "There is a definite fear among some dentists that their private practices will be overrun by Medicaid patients.)";
- the lack of qualified midlevel primary care dental providers who could offer basic reparative services to children. (Minnesota this year was the first state to authorize "dental therapists" to provide primary dental care to underserved populations, an approach previously adopted by many other countries.);
- too much dental disease is not being prevented because validated protocols to manage childhood caries as a chronic disease are still in development and the dental profession has yet to widely utilize health educators, psychologists, behaviorists, community health workers and others who are trained to help families improve their day-to-day oral health behaviors.

Given these factors, CDHP has advocated for a holistic approach to improving children's oral health, an approach that includes both public health and patient-focused interventions. Action is needed across the federal government.

- The Centers for Disease Control and Prevention (CDC) – already so effective in promoting community water fluoridation and school based dental sealant programs - can play a far greater role in educating the public about risks for and prevention of early childhood tooth decay.
- The National Institutes of Health (NIH) – which has supported nearly a decade of research in eliminating oral health disparities in children – can encourage adoption of its findings by the professions and the public.
- The Health Resources and Services Administration (HRSA) – which has so strongly promoted children's oral health through prevention, direct care, workforce development, and health information technology – can, with expanded support from Congress, leverage its programs more widely and play a major role in developing new midlevel dental providers.
- The Agency for Healthcare Research and Quality – which has substantiated oral healthcare utilization through its MEPS analyses – can invest far more substantially in improving dental systems of care.
- Head Start and WIC – traditional partners in childhood oral health promotion - can engage in active demonstrations of best practices to improve children's dental care.
- And CMS – the subject of this hearing - holds plays a particularly powerful role as a funder and regulator of care for underserved children.

Because the purpose of this hearing is to discuss what the Centers for Medicare and Medicaid Services (CMS) can do, I have organized our recommendations under the broad categories previously suggested to this Subcommittee of *leadership, technical assistance,* and *oversight*.

Leadership: CMS can:

- Promote the reestablishment of a DHHS Department-wide Oral Health Initiative led by an effective coordinator in the Office of the Secretary.
- Reestablish Oral Health Leadership teams in each of the DHHS Regional Offices comprised of experts from CMS, HRSA, and the dental profession.
- Utilize its communications, regulatory, and demonstration authorities to develop and promote best practices that address core barriers to dental care for children in Medicaid.
- Hold states publicly accountable for meeting existing EPSDT program requirements.
- Prioritize dental program performance when reviewing state programs.

Technical Assistance: CMS can:

- Encourage innovation and experimentation through demonstrations with a particular emphasis on disease prevention and management.
- Feature successful interventions and provide states with practical tools for their replication.
- Ensure that quality measures being crafted under CHIPRA can be effectively implemented and tracked and are used for program improvement.
- Maximize opportunities created in CHIPRA to provide information to beneficiaries' families about the dental benefit, promote the "dental wrap," encourage contracting between FQHCs and private dentists, and maximize the potential for early parental education on caries prevention.

Oversight: CMS can:

- Continue exerting pressure on the states to meet existing EPSDT dental requirements.
- Establish systems to ensure states meet CHIPRA dental requirements.
- Improve the timeliness and completeness of Medicaid 416 reporting.
- Require states to correct existing shortcomings within the www.insurekidsnow.gov web site.

My colleagues and I at the Children's Dental Health Project look forward to working closely with CMS on actions that it can take to improve the oral health and dental care of Medicaid beneficiaries.

When I founded CDHP, I called it a "project" to reflect the reality that childhood tooth decay is a solvable problem. Congress, federal agencies, dental authorities, and child advocates can work together toward eradicating this scourge by identifying those at greatest risk early in their lives, providing families with the tools to manage that risk, ensuring ready access for all children to comprehensive prevention-oriented dental care, and allocating our resources where the needs are greatest. I look forward to continuing to work with this Subcommittee, CMS, and all who care about children's oral health to achieve the goal of healthier children.

That concludes my testimony. I am happy to answer any questions that the Committee may have.

Thank you.