Testimony of Burton L. Edelstein DDS MPH

Professor of Dentistry and Health Policy & Management
Columbia University

Chairman of the Board
Children's Dental Health Project

on
"One Year Later: Medicaid's Response to Systemic Problems Revealed by the Death of Deamonte Driver"

before the
Domestic Policy Subcommittee
House Oversight and Government Reform

February 14, 2008

Mr. Chairman and Members of the Subcommittee,

I appreciate the opportunity to testify today about the federal government's roles and responsibilities in ensuring that children in Medicaid have access to the dental care that is promised to them by federal law. My name is Dr. Burton Edelstein. I am a professor of dentistry and health policy at Columbia University and serve as Board Chair of the Children's Dental Health Project, an independent non-profit organization committed to improving children's access to oral health.

In my role as a professor, I have taught my students that public policymaking is the process through which government prioritizes and allocates resources to competing interests. We observe that dental care has fared very poorly in this competition:

- Medicaid significantly underfunds pediatric dental services relative to the funding level of the public at large. While approximately 5% of pediatric healthcare spending in Medicaid goes to dental services, five times more - roughly 25% - of the American public's pediatric healthcare spending goes to dental services. Given that children in Medicaid have, in general, poorer oral health status and greater needs for dental care, this disparity is particularly telling about the underfunding of dental care in Medicaid. CMS reports expending an average annual amount of $2900 per child beneficiary. AHRQ contrasts spending levels in Medicaid with spending levels for other funding sources showing that publicly covered children in 2004 had expenditures of only $272 compared with $635 for commercially insured children and $470 for children with no dental coverage.

- Only one-in-three children enrolled in Medicaid obtains dental services in a year. While this proportion is more favorable than in past years (i.e. approximately 20% in 1996, 25% in 2000), it continues to represent significant under-attention to dental services for children who are most impacted by dental disease. Children in commercial dental benefit plans typically access care at more than twice the rate of Medicaid-enrolled children. Even the most conservative federal estimates of dental care utilization by children, from the 2004 Medical Expenditure Panel Survey, show that nearly half of middle income and two-thirds of high income children obtain a dental visit in a year compared with only a third of poor and low income children, despite Medicaid requiring that states provide levels of care that are equivalent.
- Adult dental needs are often ignored altogether. Information tracked by the American Dental Association reveals that in 2006 15 states provided only "emergency" services, those treatments necessary to relieve pain and infection, while 7 states failed to provide even this minimal level of coverage. Only 9 states provide adults with a package of benefits that dentists would regard as reasonably comprehensive. The lack of adult coverage, coupled with the lack of dental benefits in Medicare and the optional provision of dental services in SCHIP, collectively reveal that federal policymakers fail to appreciate basic dental services as an essential component of primary healthcare. This lack of coverage for adults is particularly problematic for low income adults and for children with special healthcare needs who age out of Medicaid's EPSDT coverage at age 21.

Despite the past lack of attention to basic oral health coverage and service assurance by the Centers for Medicare and Medicaid Services (CMS), we also recognize that CMS has many options at its disposal to improve this situation by exercising leadership, providing technical assistance, and holding states accountable for required performance.

When we look at dental care in Medicaid, we note how little, how infrequent, and how inadequate are federal efforts to ensure that children have at least access to basic dental services that are essential for growth, health, and function. With the specific exceptions of HRSA's oral health programming (particularly in the Maternal and Child Health Bureau), NIH-sponsored research to eliminate oral health disparities, CDC's promotion of preventive programs (water fluoridation and sealants), and the Head Start Program's oral health requirements, there are few examples of focused, active, engagement in improving children's oral health even as CDC reports that dental disease is increasing among young children for the first time in 40 years. Particularly lacking among federal efforts are those that attend specifically to dental care financing for low-income children in Medicaid by ensuring that states comply with existing federal law and regulation regarding the delivery of services in EPSDT. Needed is both a specific, visible, and demanding effort by CMS to "fix dental Medicaid" (as a handful of states have demonstrated is possible) and a coordinated oral health effort across the Department of Health and Human Services that specifically advances dental prevention and disease management strategies that hold promise to simultaneously reduce disease burden and lower treatment costs. The "win-win" of better health at lower cost should become a hallmark of federal efforts to improve children's oral health and use of dental services.

Addressing the source of the growing disease burden is essential because the US dental system's capacity is, and will remain, insufficient to address the backlog and new occurrence of tooth decay in children. For example, with over four million children born each year and a cavity rate among 2-to-6 year olds of 28%, there are roughly 4.5 million toddlers and preschoolers who already have visibly evident tooth decay prior to entering Kindergarten. With only a small proportion of general dentists seeing such young children and a limited supply of pediatric dental specialists, fitting even this subset of children into the existing delivery system would be very challenging. But with the disease concentrated among children of the poor who are covered by Medicaid and less than 20% of dentists participating in this program, the possibility of "fitting" these children into the available delivery system is wholly impossible. Therefore, a new and concerted effort to reduce disease burden, focus care on children at greatest risk, and maximize the capacity of dental Medicaid programs is essential.

Most surprising to us is the paucity of attention paid to dental Medicaid in the year following the death of Deamonte Driver – not because the incident was so extreme (as it surely was) but because it so blatantly highlighted the importance of the dental Medicaid program for children. Yet unknown is the overall morbidity and mortality associated with common tooth decay in children. Anecdotally, dental educators note that Deamonte Driver's experience of a brain abscess secondary to a dental infection is not an isolated case. Indeed, many hospital-affiliated dentists report personal awareness of such cases as well as incidences of other head and neck infections stemming from decayed teeth. More

generally recognized is the functional morbidity suffered by children as a result of chronic and intermittently acute dental pain and infection. For example, one recent study of children presenting to pediatric dentistry training programs for “dental emergencies” reported that the majority (57%) were enrolled in Medicaid and that 38% had obvious functional impairment. When assessed for level of pain experienced, 22% of children reported the highest level of pain on a standardized pediatric pain assessment tool. Pain had been experience for several days by 73% of children. Functional consequences reported by parents included difficulty eating, sleeping, attending school, and even playing.

As a consultant to the Department of Health and Human Services from 1998 to 2000, I came to know dental Medicaid through a formal joint HRSA-CMS dental access initiative. Under the two national Medicaid Directors who preceded the current Director a long list of actions were taken to stimulate improvements in dental care for low income children:

- the 10-year vacant CMS chief dental officer position was filled and situated within the Center for Medicaid and State Operations with direct access to the Medicaid Director. The current dental officer at CMS is not similarly situated.
- a joint-agency Technical Advisory Group, or TAG, was formed to answer policy questions about the Medicaid dental program. A wide range of issues was addressed but the final report was not released by the current Medicaid Director.
- DHHS Regional Office capacity was bolstered. A dedicated three-person team comprised of a federal dental public health officer, a Medicaid official, and a

pediatric dentist consultant was established in each office. These teams have ceased functioning.

- CMS and HRSA joined forces with the National Governor's Association and the National Conference of State Legislatures to encourage and assist states. A series of "Policy Academies" and meetings were convened to encourage state policymaking on dental access for low-income children. Many of the most noteworthy reforms arose from these efforts which also have not continued.
- CMS funded demonstrations that showed cost saving *and* better oral health outcomes. The North Carolina *Into the Mouths of Babes* program was initiated by research and development funding at CMS and has subsequently continued with HRSA support. It is a model prevention program worthy of replication.
- The Medicaid Guide was commissioned under contract with the American Academy of Pediatric Dentistry but significantly redacted by CMS before its delayed release.
- State 416 performance reporting was strengthened. A new measure was developed (Lines 12 a, b, c) to better reflect the *quality* of care provided in addition to the *numbers* of children served. The value of this refined dental measure has been eroded by failure of CMS to press states to ensure that care provided by managed care contractors is accurately reported in their 416 reports.
- States were required to report to CMS on their efforts and plans to further improve dental care for children in Medicaid. No known effort was made by CMS to follow up on those submissions or to encourage states to implement their improvement plans.

As we now know, not one of these efforts was continued into the current Administration

seven years ago and only in recent months are the TAG and state investigations being re-initiated. Given the long lag time between policy reform and program performance improvements, it appears that the above-listed concerted efforts account for the improvements that were noted in dental utilization by children in Medicaid during the period 1996 to 2007. Had these efforts been continued, utilization rates closer to commercially insured children may have been achieved.

And yet, during recent years a small number of states have demonstrated the capacity to markedly improve dental Medicaid performance. These experiences need to be recognized by CMS, highlighted for state policymakers, and replicated widely. Examples include but are not limited to:

- the Tennessee reform which was the first to "carve out" dental services from medical managed care contracting, established a "non-risk" management relationship with a single dedicated dental vendor, Doral Dental, and thereby aligned incentives so that higher utilization is recognized rather than punished and the quest for profits do not compete with the goal of improved access.
- the Rhode Island RiteSmiles program developed by United Healthcare's Americhoice Medicaid division to build infrastructure that addresses the youngest children through intensive dental disease prevention. This program trains and incentivizes healthcare practitioners to see young children in Medicaid, assess risk for early onset disease, counsel families in disease prevention, and deliver topical fluoride varnishes that hold strong promise to reduce disease initiation and progression.

- the Delaware Medicaid reform that streamlined administration by simply paying dentists at 85% of submitted charges and rebuilt a network of providers that had failed overwhelmingly.

CMS is uniquely positioned to identify, feature, and promote such successful programs in its role as the national agency responsible for Medicaid performance. In fact, its current dental website is a start to such dissemination but currently provides only minimal information.

As a participating clinician, I have come to personally experience the difficulties facing practitioners who seek to treat vulnerable children—difficulties that arise from a poisonous mix of low-payment and unnecessarily burdensome administration. As a result, parents still struggle to find care for their children. Yet my practice's experience with another governmental dental insurance program for children, the Department of Defense's Tricare Dental Program, shows that government *can* make dental programs work. Twice the proportion of military dependent children in the well-funded and managed Tricare program obtain dental care as do children in Medicaid. The network of participating providers is vast and well distributed to meet the needs of military families – at least two and a half times greater than the number of dentists participating in Medicaid. The Department of Defense works collaboratively with its dental insurance vendor, United Concordia, to monitor performance, ensure continuous quality improvement, incrementally increase target utilization levels, and reach out to beneficiaries. The contrast between these two programs is both stark and telling about federal priorities and commitments.

So what could CMS do? I would suggest three things ranked from the least to most demanding:

1. *Exercise leadership:* CMS, and particularly the Director of the Office of Medicaid Services, could ensure that CMS staff, the staff in all regional offices, and state Medicaid directors know that dental care is not only federally required by EPSDT but it is an explicit priority. It could promote evidence-based early intervention that starts dental care before the start of disease by age two and put the "E" for Early back into EPSDT. With little expenditure of time and money, CMS could again partner with HRSA as well as with other federal agencies including CDC, ARQH, IHS, NIH WIC, Head Start, foundations, professional associations, and others to leverage each others' capacities, explore creative solutions, and prioritize dental care for children.
2. *Provide meaningful technical assistance:* CMS could provide intensive and extensive technical assistance to states – it could identify and promote best practices, issue guidance, release the complete Medicaid guide and TAG's findings, develop and disseminate model contracts, convene states to learn from one another, ensure a competent and ready cadre of regional officials, and develop novel Medicaid solutions that are now available under the HIFA and DRA provisions. When problems arise in dental program—as happened most recently in Georgia and Connecticut—CMS could offer its immediate assistance. For example, CMS did not engage in technical assistance when Georgia's for-profit medical managed care vendors sought to decrease access after experiencing

unanticipated high utilization. As a start, its current "Medicaid Dental Coverage" website could be dramatically expanded, promoted, and enhanced.

3. *Exercise oversight:* CMS has clearly demonstrated its willingness and capacity to act forcefully when it desires to do so, as evidenced for example by the August 17th stringent guidance to states on program expansions. Why CMS has not acted forcefully on the dental crisis is inexplicable unless one believes that even the death of a child cannot highlight the importance of basic dental care. A federal directive to states that compliance with reporting and service requirements is mandatory would bring attention and action where it is sorely needed and would capitalize on past efforts that are now so sadly stalled.

Taken together, the exercise of leadership, technical assistance, and oversight could bring dental care to the fore, honor Deamonte Driver's life, and assist the millions of children in Medicaid who currently have so little access to needed care.