



**STATEMENT OF HERB B. KUHN  
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CENTERS FOR MEDICARE & MEDICAID SERVICES**

**ON**

**"NECESSARY REFORMS TO PEDIATRIC DENTAL CARE UNDER MEDICAID"**

**BEFORE THE HOUSE COMMITTEE ON OVERSIGHT  
AND GOVERNMENT REFORM**

**SUBCOMMITTEE ON DOMESTIC POLICY**

**September 23, 2008**

**Testimony of Herb B. Kuhn**  
**Deputy Administrator and**  
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**on**  
**Necessary Reforms to Pediatric Dental Care under Medicaid**  
**Before the**  
**House Committee on Oversight & Government Reform**  
**Subcommittee on Domestic Policy**

**September 23, 2008**

Good morning Chairman Kucinich and members of the Subcommittee. Thank you for the opportunity to provide an update on the initiatives the Centers for Medicare & Medicaid Services (CMS) has taken with regard to dental care for children served by the Medicaid program.

As you know, Medicaid is a shared partnership between the Federal Government and the States that will provide more than \$368 billion in medical services in Fiscal Year (FY) 2009. Although the Federal Government provides financial matching payments to the States, each State designs and runs its own program within the Federal structure and is responsible for administering its Medicaid program. The States enroll providers, set reimbursement rates, and negotiate managed care contracts. CMS works with State Medicaid agencies to encourage quality care, adequate access, and appropriate use of Federal Medicaid matching funds.

It is CMS' goal to protect Medicaid's integrity, promote efficient operations, and ensure safe and quality health care for all recipients. In this manner, there have been a number of important developments for improving oral health since my predecessor's testimony before you in February 2008. Specifically, I will discuss the reviews we have conducted, outreach we have made, and assessments we have provided to the States.

## **CMS Response to Improving Oral Health**

As noted earlier, States administer the Medicaid Program with general oversight from CMS. As such, CMS is committed to working with the States to improve oral health. CMS seeks to support States in their efforts to improve services through interventions focused in three strategic areas: improved access to required dental services, reimbursement aligned with desired outcomes, and attention to the quality and transparency of dental services provided. However, because, by design, each State's program is unique and targeted to the population served and because there are several barriers, identified by the Centers for Disease Control (CDC), to receiving dental care, there is no one single activity that can be implemented to stimulate improvement. Improving oral health requires a robust process which looks at the unique attributes of each State's program.

As a result, CMS completed 17 State dental reviews in the past seven months to assist us in obtaining data on these three strategic areas to improve oral health. The findings from these reviews will be summarized in a national report and used to inform future policy and improvement activities in the three strategic areas.

### **Status of CMS Focused Dental Reviews**

The States CMS targeted for review were primarily those that reported a thirty percent or less dental services utilization rate for children receiving Medicaid, as reported on the 2006 CMS-416 forms. CMS also reviewed an additional State that had a higher utilization rate of thirty-six percent, but which raised concerns related to the implementation of that States' managed care program.

The purpose of the reviews was to determine what efforts each State had made to address the issue of dental underutilization for children in that State and to make recommendations on additional steps the State should take to increase these utilization rates. Specifically, the CMS review team interviewed State officials, contractors, managed care organizations, as well as a sample of providers. The review team also conducted extensive document review in the areas of outreach periodicity, access, diagnosis and treatment services, support services, and coordination

of care. Additionally, the Center for Medicaid & State Operations (CMSO) reviewed information collected from families of children covered by Medicaid.

Following these reviews, draft reports were completed for every State that was reviewed. Four reports have been finalized and released (MD, ND, AR, and MT) and 7 additional draft reports have been sent for comments to the respective States. In addition to finalizing the remaining reports, CMS is currently analyzing the report findings to prepare a National Summary of the dental reviews. While the comment period has not been completed for some States, CMS has already identified certain trends that will be discussed in the National Summary Report. In short, CMS observed that States with lower utilization of children's dental services frequently required improvements in the following areas:

- Clear information for beneficiaries that was linguistically and culturally appropriate regarding the availability and importance of dental services and how to access the services;
- Process to remind beneficiaries that recommended visits were due;
- Updated dental provider listings;
- Process to track whether recommended visits occurred;
- Availability of dental providers, particularly in more rural portions of the State;
- Availability of specialists for referrals; and
- Availability and reliability of transportation to dental services.

Providers frequently offered the following barriers to their participation as a Medicaid Provider:

- Low reimbursement rates;
- Missed appointments without the ability to recoup a "no show" fee;
- Burdensome prior authorization processes; and
- Rejection of claims without a satisfactory explanation.

Additionally, CMS reviewed data from the National Health and Nutrition Examination Survey (NHANES) collected by the CDC on the barriers to receiving children's dental services, as reported by families. The reasons the families most frequently cited as barriers included:

- The belief that they cannot afford dental care;

- Problems obtaining approval for care;
- The provider's refusal of their insurance plan; and
- Not knowing where to go to get care.

Also, CMS plans to further evaluate several promising practices we identified, such as:

- Streamlined administrative processes;
- Use of mobile dental services; and
- Collaborations with Head Start or other public health programs.

After completing the final reports, CMS will develop additional strategies and policy options that can help support States in their efforts to address the issues identified. CMS will also convene a town hall meeting to discuss the National Summary Report and policy options, as well as convene Medicaid recipient focus groups. Finally, based on the findings from the final reports, CMS will require corrective actions for those States not in compliance with Federal Regulations.

#### Periodicity Schedule Reviews

In addition to the 17 State focused reviews, CMS collected information on the availability of Dental Periodicity Schedules from all 50 States and the District of Columbia. Our initial review indicated that all but three States reported having some type of periodicity schedule, although they were not all in compliance with the CMS requirements. For example, some of the schedules provide a timeframe for when a primary care physician should refer the child for a service, but did not specifically address how often the actual dental service should occur. Additionally, CMS found that several of the periodicity schedules were not easily accessible by providers and beneficiaries.

As a result, the CMS Regional Offices contacted all the States outlining the expectations of an oral health schedule that is separate and distinct from the general health screening schedule. We noted that the schedule should be developed in consultation with recognized dental organizations involved in child dental health care. States were instructed to provide these schedules to CMS by September 1, 2008. As of this date, 38 States have provided acceptable periodicity schedules

and 7 other submissions were found to have insufficient information. Some States reported that they were still working with their professional societies, while others have not responded to the initial request. The CMS Central Office has contacted the States that have not responded to inform them that it is our expectation that they adopt the periodicity schedule recommended by the American Academy of Pediatric Dentistry, if they cannot provide us with an approved schedule by October 15, 2008.

#### Other CMS Activities

In addition to the reviews, CMS is working on a number of other activities in coordination with the States to improve access to quality dental care for Medicaid eligible children. Some of the actions that we have taken include the following:

- In collaboration with the National Association of State Medicaid Directors, CMS developed an Oral Health Technical Advisory Group (TAG) and has held four meetings to date. The TAG is currently working on revising the policy paper on dental questions and answers that this Subcommittee inquired about during the February 2008 hearing. The paper is currently in the final stages of review and we plan to have it published on our website by the end of the month. The TAG is also considering improvements to the CMS-416, the annual EPSDT reporting form, to determine if we can better capture the array of oral health services that are being delivered in different settings. During our last TAG call we began to address the issue of improving the materials used to inform beneficiaries of the dental services they can receive under Medicaid.
- In addition to the TAG, we have received information from the American Dental Association (ADA) regarding the formation of a Dental Quality Alliance (DQA). The ADA Board of Trustees has indicated a willingness to explore this Alliance with its House of Delegates at its meeting in mid-October. These efforts require collaboration across all parties involved with healthcare. One goal of the Alliance will be to bring about consensus in the area of evidence-based performance indicators that can be used to measure improvements in access and quality consistently throughout the country.

- Additionally, the Director of the Medicaid Quality Division of the CMS CMSO and the CMS Chief Dental Officer have met with the American Academy of Pediatric Dentistry and the Medicaid and SCHIP Dental Association. As a result of these actions, they served as featured presenters at the National Oral Health Conference that was held April 28-30, 2008. This conference was sponsored by the American Association of Public Health Dentistry and the Association of State and Territorial Dental Directors. This presented an excellent opportunity to share the findings from the CMS-416 data, share results from the focused dental reviews, and determine how to work together to improve access in the future and to keep the momentum going forward. The American Academy of Pediatrics is also sponsoring an Oral Health Conference this fall.
- We have also worked to share innovative practices directly with the States. Our spring 2008 Quality Teleconference Call held on April 3, 2008 focused on promising practices in children's dental care. The Conference included presentations on innovative approaches to financing dental care, including information from the State of North Carolina on its "Into the Mouth of Babes" program, the State of Tennessee's approach to increasing provider participation and access, the State of Michigan's Healthy Kids Dental program and the State of California's proposed dental performance measures for their SCHIP population. The conference call was well received and there were over 400 participants.
- We also have several dental "promising practices," including some from the 2008 Quality Teleconference Call, on the CMS website and are continuing to work with other States to disseminate information regarding their programs. Additionally, earlier this month we funded a contract to explore child health promising practices in Medicaid and SCHIP in nine States. Although only nine States will be involved in the project, we may receive multiple promising practices from a State. This contract ends in December and we hope a final report will be available early next year.
- Last year we also established a Medicaid Quality Improvement Goal to improve States' abilities to assess quality of care and move toward the development of a national framework for quality. We have developed a comprehensive state-specific Quality Assessment Report that provides an analysis of nearly every quality activity

occurring in a state Medicaid or SCHIP program. Dental services are included among the various performance areas. To date, we have completed eight Quality Assessment Reports. Feedback from the States has been very positive and they have indicated that this report will serve them well as a tool in their quality improvement efforts. Some States have actually requested that they be next in line to receive a quality assessment.

- We continue to hold regular meetings with all the Regional Office EPSDT/Dental Coordinators to discuss various child health activities including the importance of providing technical assistance to and oversight of States in the area of CMS-416 reporting for EPSDT and dental services. We are working aggressively to ensure the accurate submission of dental services data on the CMS-416 so that we can continue to analyze and monitor progress in the provision of dental services. We have received 2006 data from all but one State. We are working with the one State, which continues to have problems with the accuracy of its data. The 2007 data was due on April 2008. We have received data from all but five States and we continue to work with these States on their submissions. We also continue to explore additional avenues of data collection. This month we funded a contract that will focus on helping many Medicaid Managed Care Organizations collect quality performance information in a consistent manner, so as to allow for benchmarking on various quality measures with plans across the country. We are also working with the National Committee on Quality Assurance on child health measures, reviewing existing measures and new measures that have a preventive care focus.

### **States Response to Improving Oral Health**

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While CMS support is important, real change in the system occurs at the local level by State administrators, local providers and their patients. The Oral Health TAG has been very helpful in identifying successful State practices. Following are some examples of actions States have taken to improve oral health services.

### Maryland

As the Subcommittee is aware, Maryland formed a Dental Action Committee that developed a Dental Action Plan that was submitted to the State's General Assembly, which ultimately is responsible for providing the necessary funding to support the recommendations for increased reimbursement. The General Assembly approved many components of the plan and Maryland is in the process of implementation. CMS regional office staff conducts regular monitoring of the progress in the State of Maryland. The State highlights the following activities as recent accomplishments:

- The State developed and issued a request for proposals (RFP) for a single statewide vendor to coordinate and administer dental benefits for Maryland Medicaid beneficiaries. This will require the State to carve dental services out of the Managed Care Organization (MCO) service package under the HealthChoice Program and have them administered through a single Administrative Services Organization (ASO). Maryland expects this change to be implemented by July 2009. The long-term goal will be to ensure that every child with Medicaid coverage has access to a dental home. We understand the bids are currently under review by the State.
- The Maryland Governor's FY 2009 budget included \$14 million as the first installment of a three-year effort to bring Maryland Medicaid dental rates up to the 50<sup>th</sup> percentile of the American Dental Association's South Atlantic region charges. This multi-year initiative is critical in attracting additional providers. The first year of the fee increase was approved by the Maryland General Assembly and was implemented on July 1, 2008. The first codes to be targeted for increases were diagnostic and preventive codes which were poorly paid in the past, but should now compare very favorably with other state rates.
- The Maryland Governor's budget included new funds to enhance the dental public health infrastructure. These funds will help establish new dental public health clinics in the southern and eastern shore regions of Maryland where there are no existing dental public health facilities. Further, these funds will be used to increase operational support for existing local health department dental clinics thereby increasing access to oral health services for low-income children statewide. In addition, this enhanced funding will allow the Office of Oral Health to provide

expertise to local health departments as they construct these clinics and implement oral health programs. Multi-year funding will be necessary to ensure the success of these and other local health department dental clinics and to build additional dental health clinics in underserved areas of the State.

- The State passed legislation during the last legislative session to allow for an increased scope of practice for public health dental hygienists in Maryland. This will help provide preventive services, such as fluoride varnish, to more children with Medicaid coverage.

#### Vermont

Vermont has implemented a “Dental Dozen” Initiative which is a comprehensive program for State Fiscal Year 2008 and beyond. The Dental Dozen outlines 12 targeted initiatives to improve oral health for all Vermont residents. The initiative includes such items as reimbursing primary care physicians for oral health risk assessments, increasing dental reimbursement rates, placing dental hygienists in each of the 12 district health offices, collecting data on missed appointments, and several other payment incentives.

#### Pennsylvania

Pennsylvania has embarked upon targeted fee increases for select dental preventive services and treatments. This includes several significant increases in July 2008 for restorations, endodontics, crowns, extractions, and orthodontics in support of the Dental Disease Management Program. The State has also revamped its prior authorization process, based on historical data, so that selected dental services, which provide little financial risk, no longer require prior authorization. Also in 2008, Pennsylvania modified their managed care contract to include pay-for-performance and performance improvement projects in priority dental topic areas. They have also increased their outreach activities.

#### Tennessee

Tennessee was one of the first States to carve-out its Medicaid Dental Program, separating it out from other managed care services. They also hired their first Medicaid Dental Director to provide oversight of the program and established a Dental Advisory Committee. Over the past six years Tennessee notes a 129 percent increase in the dental provider network, a 43 percent

increase in utilization by enrollees, intensive outreach to encourage member participation and the collaboration of key stakeholders including organized dentistry.

#### Alabama

The Alabama Medicaid Agency has successfully worked with the Alabama Chapter of the American Academy of Pediatrics and the Alabama Academy of Pediatric Dentistry to add coverage of oral health risk assessment and fluoride varnishing in the pediatric medical home for children from six months to three years of age. The program will be called First Look and will be effective January 1, 2009. This collaborative effort will be utilized to revise and expand the First Look Project that was originally developed in 2004, where pediatric primary care providers were provided with resource information and guidelines to assess their patients and provide appropriate guidance to the families. Additionally, in January 2007 the State added procedure codes to encourage providers to see patients before the age of 3. They continue to make detailed changes on a quarterly basis within the Dental Chapter of the Alabama Medicaid provider manual to encourage quality of care by the providers.

#### Connecticut

Effective April 1, 2008, Connecticut increased pediatric dental fees by \$20 million. They also provided \$4 million in grants to safety net providers to expand access. The State carved out dental services to a non-risk Administrative Service Organization effective January 2008 and increased their dental provider panel by more than 100 percent. They have now dedicated \$250,000 to a contract to expand outreach to providers.

#### **Conclusion**

CMS continues to make strides in engaging the States to make joint efforts to expand the use of dental services among Medicaid children and in our ability to report such progress to the public. As noted above, CMS is working on a number of activities in coordination with the States and we are continually considering initiatives to improve. Upon the conclusion of our National Summary Report, which will summarize the findings and trends from the focused State reviews, we anticipate developing a plan of action that will further the objectives of improved access to required dental services, reimbursement aligned with desired outcomes, and attention to the quality and transparency of services provided. We know we must remain vigilant and proactive.

Thank you again for the opportunity to speak with you today. I look forward to answering any questions you might have.